1988

Automobile And Other Insurance.

104 Automobile and Other Insurance. Initiative Statute

Official Title and Summary Prepared by the Attorney General

AUTOMOBILE AND OTHER INSURANCE. INITIATIVE STATUTE. Establishes no-fault insurance for automobile accident injuries, covering medical expenses, lost wages, funeral expenses. Accident victim may recover from responsible party only for injuries beyond no-fault limits. Prohibits recovery for noneconomic injuries except cases of serious and permanent injuries and specified crimes. Reduces rates for certain coverages 20 percent for two years. Cancels Propositions 100, 101, 103. Restricts future insurance regulation legislation. Requires arbitration of disputes over insurers' claims practices, limits damage awards against insurers. Prohibits agents and brokers from discounting. Increases Insurance Commissioner's power to prosecute fraudulent claims. Limits plaintiffs' attorney contingency fees in motor vehicle accident cases. Summary of Legislative Analyst's estimate of net state and local government fiscal impact: Would increase state administrative costs by about $2.5 million in 1988–89, varying thereafter with workload, to be paid by additional fees on the insurance industry. State and some local governments would have unknown savings from lower insurance rates and liability limitations. Possible but unknown effect on recovery of workers' compensation. Possible reduction in court costs and court revenues could result from limitations on claims for noneconomic damages. Would reduce state revenue from the gross premiums tax by about $25 million a year for two years if no other changes are made in insurance rates.

Analysis by the Legislative Analyst

Background

Various types of insurance are sold in California, including automobile, liability, fire, health and life. In 1987, insurance companies collected about $50 billion in premiums from the sale of insurance. In turn, they paid about $1 billion to the state in a tax on these premiums.

Motor vehicle insurance is one of the major types of insurance purchased in the state. It accounted for about $12 billion (24 percent) of all premiums collected during 1987. Such insurance may include protection for:

- Liability and property damage (which covers claims for bodily injury and property damage to others when the insured person was at fault);
- Medical (which covers the insured person and others in the automobile, regardless of fault, for "excess" medical expenses, meaning those expenses not covered by other insurance);
- Collision (which covers collision damage to the insured's car regardless of the fault of the insured);
- Comprehensive (which covers damage other than collision, such as fire, theft, glass breakage and vandalism, to the insured's car); and
- Uninsured and underinsured motorist (which covers claims for bodily injury and/or property damage caused by a motorist who is at fault and who has no insurance or inadequate insurance).

Rate Setting by Insurance Companies. Currently, insurance companies set rates for various types of insurance, using a number of factors. For motor vehicle insurance, these factors generally include the age, sex, marital status, driving record, type of vehicle and home address of the insured. The insurance companies also take into consideration other factors such as their claims experience, income and expenses. Insurance companies are not required to tell the public what relative weight they give to these factors when setting rates. In addition, insurance companies are not subject to the state's antitrust laws.

Role of the Department of Insurance in Reviewing Rates. Currently, the Department of Insurance does not review and approve insurance rates before they take effect. Instead, the Department of Insurance can request insurance companies to justify such rates *after* they take effect, as part of the rate examination process or in response to complaints from consumers. Historically, the scope and frequency of rate examinations have been limited.

Current Method of Settling Claims. Currently, the party who is "at fault" in an accident is responsible for paying compensation for both bodily injury and property damage.

If a claim for damages is filed and one or more of the parties involved in an accident is insured, insurance companies attempt to determine who is at fault. These claims are usually settled by negotiations or by court action. After it is determined which party is at fault, the insurance company of that party pays the damages, not to exceed the limits of the insurance policy.

Attorney Fees. Attorney fees in motor vehicle accident cases are usually based on a percentage of the amount the client recovers and are referred to as "contingency fees." The fees are fixed by a contract between the attorney and client. There are no dollar limits on contingency fees in these cases.

Proposal

In summary, this measure:

- Establishes a "no-fault" motor vehicle insurance system that (1) pays benefits up to specified limits to an accident victim who suffers bodily injury and (2) permits individuals to sue for losses which exceed those limits.
- Limits noneconomic losses (such as "pain and suffering") and attorney contingency fees.
- Requires a two-year reduction in certain motor vehicle insurance rates.

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This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds, amends, and reenacts sections of the Insurance Code, and amends and adds sections of the Vehicle Code: Therefore, existing provisions proposed to be deleted are printed in ~~strikeout type~~ and new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Title.

This initiative shall be known as the Insurance Cost Control Act of 1988.

SECTION 2. Findings and Declaration.

The people find and declare as follows:

1. Insurance costs, the number of claims and lawsuits, and the size of jury awards have increased greatly in California in recent years. A large percentage of court awards goes to pay legal fees and court costs. These costs are ultimately passed on to the public in the form of higher insurance premiums.

2. A system of no-fault automobile insurance will reduce wasteful litigation, speed payment of claims, and help stabilize insurance costs. A no-fault system which mandates a two year statewide average reduction in the rates for basic automobile insurance for personal injuries (including no-fault insurance, liability insurance, medical payments and uninsured motorist insurance) will result in automobile insurance premium savings.

3. A no-fault automobile insurance system should (a) provide that specified compensation for bodily injuries be paid directly by the insured's insurance company regardless of fault, (b) allow compensation for property damage and additional compensation for serious and permanent injuries to continue to be based on the present fault system, (c) place limits on attorneys' contingency fees, and (d) provide that no insurance company can cancel, refuse to renew, or increase the rate charged any person for any insurance policy solely on account of any prior payment of a no-fault claim.

4. Penalties should be increased for uninsured motorists.

5. Insurance rates should be established by competition in the open market.

6. Fraudulent insurance claims have resulted in greater insurance costs requiring stronger anti-fraud laws.

7. The insurance Commissioner should impose penalties and fines on insurance companies which unlawfully discriminate in setting rates, and should hear evidence from consumers in proceedings before the Commissioner.

8. Arbitration procedures should be established to allow disputes regarding claims under liability insurance policies to be resolved without costly litigation.

SECTION 3. Purpose.

The people enact this initiative to control the cost of insurance in California by establishing a no-fault system to govern motor vehicle accident claims, by increasing penalties for uninsured motorists, by requiring that insurance rates be established by market competition, by providing an option for speedy resolution by arbitration of disputes with insurers over liability claims and by regulating insurance fraud and anti-competitive insurance company practices.

SECTION 4. California Guaranteed Protection Plan.

There is hereby added to Division 2, Part 3 of the Insurance Code the following Chapter 6, commencing at Section 12001, which shall be known as the California Guaranteed Protection Plan:

12001. Definitions.

(1) "Accident victim" or "victim" means a person suffering personal injury as defined in this Section.

(2) "Basic loss benefits" means (i) required loss benefits and (ii) optional loss benefits.

(3) "Disability" means medically established inability of a victim to perform the usual and customary duties of the victim's occupation.

(4) "Government" means the government of the United States, Canada, any state, the District of Columbia, any Canadian province, any political subdivision of any of the foregoing entities, any instrumentality of two or more of the foregoing entities, or any agency, subdivision, or department of any such government, including any association or other association organized by a government for the administration of a government program and subject to control by a government, or any corporation or agency established under an interstate compact or international treaty.

(5) "Insurance" means any policy of insurance, contract, or other undertaking by a duly authorized insurer, self-insurer, or obligated government to pay or provide basic loss benefits in accordance with this Chapter with respect to the ownership, maintenance, or use of one or more specified motor vehicles or classes of motor vehicles, to which such insurance shall be deemed applicable.

(6) "Insured" means, with respect to basic loss benefits:

(a) an individual (hereinafter referred to as a "named insured") identified by name as an insured in a contract of insurance pursuant to this Chapter for any vehicle for which that policy provides insurance; and

(b) a spouse or other relative of a named insured, or an individual below the age of 18 in the custody of a named insured or in the custody of a relative of a named insured, provided such spouse, other relative, or individual is:

(i) neither a named insured in any other contract of insurance in accordance with this Chapter nor obligated to maintain insurance in accordance with this Chapter for any vehicle for which the contract of insurance under which such person claims to be insured does not constitute such insurance; and

(ii) in residence in the same household with a named insured.

(7) "Insurer" includes an insurer authorized to transact business in this state or, with respect to any policy providing insurance for a vehicle registered in another state, the insurer issuing that policy, and any self-insurer or obligated government providing or obligated to provide basic loss benefits in accordance with this Chapter.

(8) "Medical rehabilitation services" means services reasonably necessary and reasonably designed to reduce the disability and dependence of a victim and to restore such person, to the extent reasonably possible at a cost which is reasonable in relation to the degree of restoration to be achieved, to his/her pre-accident level of physical functioning.

(9) "Medical expense" means reasonable and necessary charges incurred for, or (when products, services, or accommodations are provided without charge by any person who is neither the employer of the victim nor an employee or agent of such employer) the reasonable value of reasonably needed and used products, services, and accommodations for:

(a) professional medical treatment and care for personal injury;

(b) emergency medical services for personal injury;

(c) medical rehabilitation services for personal injury; and

(d) any non-medical care and treatment rendered for personal injury in accordance with a religious method of healing recognized by the laws of this State.

The term does not include that portion of a charge for a room in a hospital, clinic, convalescent or nursing home, or any other institution engaged in providing nursing care, medical care, and related services, in excess of a reasonable and customary charge for semi-private accommodations, unless medically required. Professional medical treatment and care, emergency medical services, and medical rehabilitation services are not to be considered "reasonably needed" unless (i) widely accepted as appropriate and effective for similar injuries or conditions by medical practitioners in this State or the United States, (ii) based upon scientific criteria generally accepted by medical practitioners in this State or the United States, and (iii) not of an experimental or investigational nature.

(10) "Motor vehicle" means a vehicle having more than three load bearing wheels, of a kind required to be registered under the laws of this State relating to motor vehicles, designed primarily for operation upon the public streets, roads, and highways, and driven by power other than muscular power, and includes a trailer drawn by or attached to such a vehicle.

(11) "Non-economic loss" means pain, suffering, emotional distress, inconvenience, physical impairment, loss of society, and any other non-pecuniary damage recoverable under the tort law applicable to a personal injury.

(12) "Optional loss benefits" includes (i) basic loss benefits with monetary and/or temporal limits in excess of required loss benefits and (ii) basic loss benefits provided as a result of a named insured's exercise of an option provided pursuant to Section 12011.

(13) "Owner" means the person in whose name the motor vehicle has been registered. If no registration is in effect at the time of an accident involving the motor vehicle, "owner" means the person who holds the legal title thereto or, in the event the motor vehicle is the subject of a security agreement or lease with option to purchase with the debtor or lessee having the right to possession, "owner" means the debtor or lessee.

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104 Automobile and Other Insurance. Initiative Statute

Argument in Favor of Proposition 104

NO-FAULT, PROP 104, is the only insurance measure on the ballot that saves consumers money by *truly reforming California's failing auto insurance system.*

PROP 104 is a comprehensive cost-control measure that cuts auto insurance premiums by reducing the costs driving up insurance rates—high legal costs, fraud and the burden of protecting ourselves against uninsured motorists.

This measure enacts a NO-FAULT system, where auto accident victims are guaranteed medical and work-loss benefits from their own insurance company—regardless of fault. By restricting costly lawsuits, except in cases of "serious and permanent" injuries, no-fault saves consumers and taxpayers money now and in the future.

NO-FAULT is fundamental reform that will:

- REDUCE PREMIUMS by requiring all California auto insurers to cut rates for basic personal injury coverage by an average of 20%. This will result in an immediate overall average premium reduction of 7% to 17%.
- PROTECT CONSUMERS by prohibiting insurers from canceling or nonrenewing policies, or increasing rates solely because of a no-fault claim.
- GUARANTEE rapid payment of claims. PROP 104 requires insurers to pay all valid no-fault claims within 30 days of the claim or face a stiff interest penalty.
- SAVE taxpayers and consumers money by reducing court cases. Consider these facts from the Rand Corporation: 43% of civil court cases in California involve auto accidents and the average jury trial for an injury case costs taxpayers $8,300. Other estimates show that 52 cents of every insurance dollar contested in court goes to pay legal expenses, not to compensate victims.
- PRESERVE the right to sue for out-of-pocket expenses that exceed no-fault benefit limits and for "pain and suffering" damages in cases of "serious and permanent" injuries.

PROP 104 requires all drivers to purchase a basic benefits package of $10,000 for medical expenses and $15,000 for work loss. *In 1986, 90% of all auto accident claims would have been fully covered by these basic no-fault benefits.* Drivers who want more coverage can purchase it. Motorists already covered by a health plan, or who don't need wage-replacement coverage, can save even more by purchasing less coverage at lower cost.

PROP 104 creates a new deterrent to driving uninsured because uninsured motorists cannot receive no-fault benefits and cannot sue for compensation unless they are seriously injured.

The U.S. Department of Transportation and numerous consumer organizations have praised the type of no-fault system proposed for California for providing more money to accident victims, more quickly and more efficiently than traditional auto insurance.

Don't be fooled by other initiatives that promise large premium cuts—they either do nothing to cut costs or they don't guarantee that cost reductions will be permanent.

VOTE YES on PROP 104. It is the only responsible, proven auto insurance reform. We urge you to vote for reform by voting YES on PROP 104.

DIANNE FEINSTEIN
Former Mayor of San Francisco

ALFRED F. FEDERICO
President, California State Automobile Association (AAA)

PAT NOLAN
Member of the Assembly, 41st District
Assembly Minority Leader

Rebuttal to Argument in Favor of Proposition 104

Important facts are missing from the statement above.

First, Proposition 104 was written, and is being paid for, by the insurance companies. It will not reduce rates; it will raise them. It will not protect consumers; it will permit further abuse of consumers by the insurance industry.

According to the *Los Angeles Times* (June 24, 1988), at a private meeting of insurance agents on March 14, 1988, that was secretly taped, Donald Stewart, director of the American Agents Alliance and a supporter of 104, admitted that 104 "guarantees no cost savings." Stewart also admitted that insurance companies "can change their rates the day before the election" to offset any rate reductions promised if 104 is approved by the voters.

Finally, Stewart admitted that, under 104, rates could increase by 35% for some drivers.

Second, the statement above fails to mention that there is a hidden section in 104. Its fine print cancels every reform in Voter Revolt's Proposition 103, the initiative backed by Ralph Nader. Because the insurers were afraid they would be unable to defeat 103, they decided to spend $23 million to pass 104, and hide within it regulations that would cancel everything in 103.

Where will the $23 million come from? According to the *Los Angeles Times* (July 8, 1988), $2.3 million will come from State Farm, $2.1 million from Farmers, $1.4 million from Allstate, and the rest from other insurance companies.

Every vote for 104 is a vote against real insurance reform.

Vote NO on 104.

HARVEY ROSENFIELD
Chair, Voter Revolt to Cut Insurance Rates/
Proposition 103

Argument Against Proposition 104

The insurance industry is spending millions of advertising dollars to say "Trust us. Our Proposition 104—the 'no fault' initiative—will lower your automobile insurance rates." The insurance companies don't expect you to read Proposition 104's confusing 24,000 words of legal jargon, which turn insurance law into a "your fault" system.

However, we've studied Proposition 104. It contains many traps and pitfalls for consumers.

For example, Proposition 104 allows insurance companies to continue their anticompetitive behavior and exempts them from California's antitrust and consumer protection laws. It allows insurance companies to continue to raise their rates as much as they want, without opening their books to justify them. It prevents consumers form effectively challenging insurance companies when they unfairly raise rates, cancel policies or refuse to pay a claim. It maintains the present laws which prohibit insurance agents from offering discounts. It permits insurers to continue to base rates unfairly on where you live, rather than upon your driving record. And it does nothing to lower rates for homeowner, business and other kinds of insurance. The insurance companies wrote Proposition 104 to defeat genuine insurance reform proposals on this ballot and obstruct future reform efforts.

Second, the insurance industry's Proposition 104 won't save many consumers a penny. Its promised "7–17% count" only applies to a portion of your automobile icy. The companies will be free to charge you whatever they wish for the rest of the coverage you must buy. Insurance industry representatives themselves have admitted privately that many drivers will pay more under Proposition 104.

Worse, Proposition 104 allows the automobile insurance companies to continue to raise rates through Election Day, before they give drivers the advertised "discount." Many companies have already raised prices between 10% and 20% this year—so the reduction offered by Proposition 104 is already meaningless.

Third, under Proposition 104 it will be even harder for drivers to make insurance companies pay fully for a legitimate claim. And, under their "no fault" plan, you will have to collect from your own insurance company in most cases if someone else strikes you. Under Proposition 104, careful drivers are treated the same as unsafe drivers.

Finally, Proposition 104 will not lower your taxes. In fact, Proposition 104 forces taxpayer-funded programs like Medi-Cal to pay compensation to victims first, before the insurance companies have to pay. This simply means insurance companies will pay less, while taxpayers shoulder the burden of compensation.

Auto insurance "no fault" systems written by insurance companies do not lower rates or protect consumers. A 1985 U.S. government study shows that car insurance rates are up to 40% higher in states with "no fault" systems. That's why Nevada and Pennsylvania have repealed their "no fault" laws in recent years.

Don't be misled by the insurance industry's advertising campaign. Every vote for Proposition 104 is a vote for higher rates and against needed reforms. We advise you to vote "NO" on the insurance industry's Proposition 104.

RALPH NADER
Consumer Advocate

HARVEY ROSENFIELD
Chair, Voter Revolt to Cut Insurance Rates/ Proposition 103

Rebuttal to Argument Against Proposition 104

PROP 104, NO-FAULT, IS THE ONLY INSURANCE MEASURE THAT REDUCES PREMIUMS BY PERMANENTLY CUTTING COSTS OUT OF THE INSURANCE SYSTEM. VOTE YES ON 104.

Proponents of other insurance initiatives promise temporary premium reductions. What they don't tell you is that hidden provisions of their initiatives mandate massive government intervention. They also don't tell you that bureaucracies in other states have failed miserably to hold down premiums.

Consider New Jersey, where government intervention led to an enormous state-run insurance system with a $2.5-billion deficit.

Don't believe no-fault opponents when they promise premium reductions without fundamental reform.

Only Prop 104 enacts comprehensive reform, through no-fault and other cost-control mechanisms, to regulate the costs driving up insurance rates.

PROP 104 *will:*

GUARANTEE prompt payment of no-fault claims from your own insurance company.

- PROHIBIT insurers from canceling your policy or raising your rates solely because of a no-fault claim.
- REDUCE premiums by requiring all auto insurers to cut rates for basic personal injury coverage by an average of 20%. This will result in an immediate overall average premium reduction of 7% to 17%.

Don't be misled by arguments that lump all no-fault plans together. Some no-fault laws have not worked because they were WATERED DOWN BY TRIAL LAWYERS. PROP 104 is modeled after the most successful no-fault laws nationwide.

ONLY PROP 104 REDUCES RATES IMMEDIATELY AND HOLDS THEM DOWN IN THE FUTURE THROUGH FUNDAMENTAL REFORM.

VOTE YES on PROP 104.

RICHARD U. ROBISON
President, Southern California Auto Club

BETTY SMITH
Former Chair, California Democratic Party

JIM NIELSEN
State Senator, 4th District
Vice Chair, Senate Insurance Claims and Corporations Committee

~~(h) The paying by any life insurer, or the receiving by life insurance policyholders of special compensations, or the allowing and receiving of credits already agreed upon in life insurance contracts now in force.~~

~~(i) The payment by an insurer of any portion of life insurance premiums payable by its employees pursuant to a life insurance program under which 75 per cent or more of its employees are required to carry life insurance on their lives so long as they remain in the employment of insurer.~~

~~(j) The payment or allowance of a fee or commission by one surety insurer to another surety insurer in respect to a risk on which both are counties.~~

~~763.5. The sale of the good will, business, list of policyholders or similar assets of an agent or broker in consideration of commissions or portions thereof to be thereafter earned by the use of such assets and payments of such consideration are not unlawful rebates if the purchaser is duly licensed to transact insurance and the receipt of the commissions would not constitute a violation of Section 760 if the person receiving them were licensed as an insurance agent.~~

~~764. Any person may be compelled to testify or produce evidence at the trial or hearing on a charge of violating a provision of this article, even though such testimony or evidence may incriminate him. A prosecution shall not be brought or maintained against such person for any act concerning which he thus testifies or produces evidence, except for perjury committed in so testifying.~~

~~765. If an insurer knowingly violates any provisions of this article, or knowingly permits any officer, agent, or employee so to do, the commissioner, after a hearing in accordance with the procedure provided in Section 701, may suspend the insurer's certificate of authority to do the class of insurance in which the violation of this article occurred.~~

~~766. If an insurance agent, broker, or solicitor knowingly and wilfully violates any of the provisions of this article, the commissioner, after a hearing in accordance with the procedure provided in Article 13 of Chapter 5 of this part, may suspend or revoke the violator's license.~~

~~767. Notwithstanding any provision in this article to the contrary, it shall be unlawful for any licensed insurance broker to pay a commission to an agent or broker licensed under the laws of Mexico when such agent or broker in Mexico refers to the insurance broker licensed in this state a resident of Mexico who wishes to obtain a policy of automobile liability insurance to be effective in this state from an insurer licensed in this state, and such broker negotiates and effects such a policy of insurance for such resident of Mexico.~~

SECTION 8. Technical Matters

(a) This act shall be liberally construed and applied in order to fully promote its underlying purposes.

(b) The provisions of this act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(c) If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Proposition 104: Analysis

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- Permits, but does not require, insurance companies to offer an unspecified "good driver" discount.
- Enacts other insurance-related provisions, and reenacts many provisions related to various lines of insurance which are currently in law.
- Provides that if this measure receives a higher number of votes than other measures on this ballot, then those provisions in other measures that relate to the business of insurance shall have no effect.

No-Fault System

Starting July 1, 1989, this measure establishes a no-fault motor vehicle insurance system that (1) applies only to bodily injury and (2) permits individuals to sue for losses which exceed specified limits.

This measure applies to private and commercial motor vehicles including automobiles, trucks, buses and trailers. It does not apply to motorcycles and "off-road-type" vehicles which are not registered with the Department of Motor Vehicles.

This measure contains the following features.

1. **"Basic" Benefits.** Requires the following minimum basic benefits to be paid by insurance companies to injured persons regardless of who is at fault:
   - Up to $10,000 for medical expenses;
   - Up to $15,000 for lost wages; and
   - $5,000 for funeral benefits, in case the injuries result in death.

In general, the basic benefits would not be provided to an uninsured motorist, a person driving a stolen car, or a person engaged in the commission of a felony.

This measure provides that the basic benefits shall be available only to pay medical expenses and lost wages to the extent that these expenses are not covered by workers' compensation and disability benefits.

Any dispute concerning payment of basic benefits would be decided by arbitration, and not by court trial. The arbitration would be conducted in accordance with procedures established by the Insurance Commissioner.

2. **Recovery of Workers' Compensation Costs.** Restricts the ability of employers to be reimbursed for medical expenses and wage losses paid under workers' compensation and other similar programs when employees are injured in motor vehicle accidents. Currently, an employer may recover the cost of benefits—such as workers' compensation—it provides to an employee who was injured in an accident by another person who was at fault.

3. **Additional Recovery.** Permits an injured person to recover costs in excess of the no-fault basic benefits by suing the party at fault for the accident.

4. **Noneconomic Losses.** Prohibits recovery for noneconomic losses (such as pain and suffering), except in cases involving (a) death or (b) serious and permanent disfigurement or injury. It would not limit the right to sue for damages in cases involving (a) the operation of an uninsured vehicle, (b) harm caused intentionally, or (c) specified crimes.

5. **Attorney Fees.** Limits plaintiffs' attorney contingency fees in motor vehicle accident cases involving bodily injury to the following: (a) 15 percent of the basic no-fault benefits recovered; (b) 33.3 percent of the first $50,000 recovered over the basic benefits; (c) 25 percent of the second $50,000 recovered over the basic benefits, and (d) 15 percent of the recovery over $100,000.

6. **Premium Reduction.** Requires insurance companies to reduce—by 20 percent for a two-year period (July 1989 through June 1991)—their average statewide premium rates for specified types of motor vehicle insurance. This would include rates for basic bodily injury liability, uninsured motorist and basic no-fault benefits provided under this measure. This reduction does not apply to the personal property liability damage, collision and comprehensive portions of a motor vehicle insurance policy.

Other Insurance-Related Provisions

The measure enacts other motor vehicle insurance-related provisions including the following.

1. **Claims Settlement Practices.** Requires that disputes between an insurance company and persons other than policyholders be settled by arbitration rather than by court action.

2. **Penalty.** Increases the penalty from an "infraction" to a "misdemeanor" for second and subsequent convictions for violation of the current financial responsibility laws.

3. **Insurance Fraud.** Increases the authority of the Insurance Commissioner to investigate and prosecute insurance fraud.

4. **Premium Discounts.** Permits, but does not require,

that insurance companies offer unspecified premium discounts for good drivers, defined as drivers who have not been responsible for an accident, or had a moving or alcohol or drug-abuse traffic violation, for at least three [illegible]s.

5. **Conflict of Interest in Employment.** Prohibits former employees of the Department of Insurance from representing insurance companies on certain issues that were pending before the department or in which that person participated, within one year after leaving the department.

6. **Limitation on Setting Insurance Rates.** Prohibits public officials from setting or approving insurance rates other than those for workers' compensation insurance and assigned-risk insurance.

Reenactment of Insurance-Related Provisions

This measure reenacts, without modification, various insurance-related provisions which are currently in law. These include (1) the current procedures by which insurance rates are regulated, (2) the requirement that the Insurance Commissioner be appointed by the Governor with the consent of the Senate, (3) provisions that prohibit discrimination in motor vehicle liability insurance based on various factors, and (4) provisions that prohibit insurance agents and brokers from paying a rebate to a buyer of insurance.

The reenactment of these and other provisions in this initiative would make future changes in these provisions more difficult. This is because such changes would re[illegible]re either a two-thirds vote—instead of a majority [illegible]—of the Legislature, or passage of another initiative by the voters.

Effect on Other Insurance Initiatives

This measure provides that, if it receives a higher number of votes than other measures on this ballot, those provisions in other measures that relate to the business of insurance shall have no effect.

Fiscal Effect

Costs

Department of Insurance. This measure would increase the Department of Insurance's administrative costs by about $2.5 million during 1988–89. In years following, these costs could be somewhat lower or higher, depending on workload. These costs, payable from the Insurance Fund, may require additional fees and assessments to be levied on the insurance industry.

State and Local Governments. While some local governments purchase insurance, most "self-insure" by relying upon their own resources to pay for losses and claims resulting from motor vehicle accidents. Because this measure reduces certain types of motor vehicle insurance rates and limits claims for noneconomic losses, it would result in unknown savings to the state and the affected local governments.

Recovery of Workers' Compensation Costs. This measure restricts the ability of employers to be reimbursed for medical expenses and wage losses paid under workers' compensation and other similar programs in motor vehicle accident cases. State and local governments, as employers, would experience both costs and savings from this restriction. The net effect is unknown.

Courts. Because this initiative places limits on court actions for noneconomic damage claims, it may reduce, to an unknown extent, annual state and local court costs and local court revenues.

Revenues

Insurance companies pay a tax based on the amount of gross premiums they receive each year from insurance sold in California. These tax revenues are deposited in the State General Fund.

This measure requires rates for bodily injury, uninsured motorist, and medical liability coverage to be reduced for a two-year period. These three components account for over 40 percent of total motor vehicle insurance premiums. The required rate reductions—by themselves—would reduce state insurance tax revenues by about $25 million a year. This estimate assumes that no offsetting adjustments would be made in other insurance rates—not restricted by this measure—to compensate for these reductions. Whether such adjustments would occur is unknown.

The rate reductions required by this measure would expire after two years, at the end of June 1991.

Proposition 104: Text of Proposed Law

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The term does not include the United States of America or any agency thereof except with respect to motor vehicles for which it has elected to provide insurance.

(14) "Personal injury" means bodily injury, sickness or disease, including death resulting therefrom, arising out of the use or occupancy of a motor vehicle as a motor vehicle on or after July 1, 1989 which is accidental as to the person suffering the injury; it does not include injury occurring during the use or occupancy of a motor vehicle but not arising out of such use or occupancy.

(15) "Punitive or exemplary damages" means awards or portions of awards which are imposed essentially as a punishment or a penalty and not as compensation to a claimant for whatever proven loss may actually have been incurred by such claimant.

(16) "Required loss benefits" means those benefits required by Section 12003 for economic loss arising out of personal injury.

(17) "Use of a motor vehicle" means operating, maintaining, loading or unloading a motor vehicle, except that such term does not include:

(a) occupying a motor vehicle as a passenger while not operating the motor vehicle;

(b) conduct within the course of a business of repairing, servicing, or otherwise maintaining motor vehicles unless the conduct occurs off the business premises; and

(c) conduct in the course of loading or unloading a commercial vehicle as the term commercial vehicle is defined in Vehicle Code Section 260.

(18) "Work loss" means the loss, during the life of an accident victim, of income such victim would have earned, but is unable to earn because of disability resulting from personal injury, from remunerative employment or self-employment, reduced by 90% of any income from substitute work actually performed by the victim and by 100% of the income the victim would have earned in available appropriate substitute work which he/she was capable of performing but unreasonably failed to undertake. Work loss does not include any loss of income occurring after the death of the accident victim, regardless of the cause of such loss.

12002. Compulsory Motor Vehicle Insurance Requirements.

(a) Each owner of a motor vehicle required to be registered in this State or which is operated in this State by or with the express or implied consent of such owner shall continuously provide and maintain insurance in accordance with this Chapter. Nothing in this Chapter shall be deemed to modify or repeal any existing statutory requirements of financial responsibility including, without limitation, Vehicle Code Sections 16050 to 16057 inclusive.

(b) The insurance required by this Chapter may be provided by a policy of insurance issued by an insurer authorized to transact business in this State or, if the vehicle is registered in another state, by a policy of insurance issued by an insurer authorized to transact business either in this State or in the state in which the vehicle is registered.

(c) Subject to the approval of the Commissioner of Insurance, the insurance required by this Chapter may be provided by self-insurance by filing with the Commissioner in satisfactory form:

(1) a continuing undertaking by the owner or other appropriate person to pay required loss benefits with respect to every vehicle subject to the undertaking and to perform all other obligations imposed by this Chapter and by the motor vehicle financial responsibility laws of this State to the same extent as would be required

under a policy of insurance that would comply with this Section and with those laws;

(2) evidence that appropriate provision exists for the prompt and efficient administration of all claims, benefits, and obligations provided by this Chapter and by the motor vehicle financial responsibility laws of this State; and

(3) evidence that reliable financial arrangements, deposits, or commitments exist providing assurance for payment of benefits in amounts required by this Chapter and by the motor vehicle financial responsibility laws of this State and for performance of all other legal obligations relating to such benefits equivalent to those afforded by a policy of insurance that would comply with this Chapter and the motor vehicle financial responsibility laws of this State. A person who provides the compulsory insurance provided under this subdivision is a self-insurer.

(d) A government may provide insurance with respect to any motor vehicle owned or operated by it by lawfully obligating itself to pay required loss benefits in accordance with this Chapter.

(e) The owner of any motor vehicle required to be registered in this State who operates it or permits it to be operated in this State, when he or she knows or should know that he or she has failed to comply with the requirement that he or she provide the compulsory insurance under this Chapter, shall have his or her operator's license and his or her motor vehicle registration revoked or suspended in accordance with procedures established therefor under the motor vehicle financial responsibility laws of this State until he or she shall provide the insurance required by this Chapter, and shall be subject to such other penalties as may be provided by law.

12003. Required loss benefits.

The insurance required under Section 12002 must, at a minimum, provide the following required loss benefits, in accordance with the provisions of Section 12005, to every accident victim for the following types of losses resulting from that accident:

(a) Medical expense. Benefits for medical expense, in a total amount not to exceed $10,000 per accident victim, for products, services, and accommodations furnished within three years of the accident causing the injuries.

(b) Work loss. Benefits for work loss occurring within one year from the date of the accident causing the injuries. Because benefits for work loss are non-taxable and because of savings in commuting costs and other work-related expenses, benefits for work loss shall be 80% of the work loss (after deduction of all federal and state taxes) suffered up to a maximum benefit amount of $1,000 for work loss occurring in any seven day period and a maximum total benefit for all work loss arising out of any one accident of $15,000 per accident victim.

(c) Funeral benefit. In the event death results from a motor vehicle accident within one year of that accident, a single lump sum funeral benefit in the amount of $5,000 payable to the estate of the deceased victim.

12004. Optional offer.

Any insurer may offer basic loss benefits with monetary and/or temporal limits in excess of the required loss benefits required under Section 12003. Any insurer may offer named insureds the option of purchasing any of the modified forms of basic loss benefits defined in Section 12003 which are authorized by Section 12011.

12005. Payment of benefits.

(a) Persons eligible for required loss benefits shall claim such benefits from sources of insurance in the following order of priority:

(1) If the victim is an employee, and if the personal injury results from a motor vehicle accident while such victim was using or occupying a motor vehicle furnished by his or her employer, the insurance applicable to such vehicle, if any;

(2) The insurance, if any, under which the victim is or was an insured, selected in accordance with Section 12015;

(3) The insurance, if any, covering a motor vehicle involved in the accident, if the victim is or was an uninsured occupant of such motor vehicle;

(4) The insurance covering any motor vehicle involved in the accident if the victim is not an insured and is occupying a motor vehicle neither owned by him or her nor covered by insurance, provided that an insurer providing required loss benefits to such a victim shall be entitled to indemnity for those benefits and for the costs of processing the claim from the owner of the vehicle occupied by that victim. In the event such owner has made any claim against that insurer or against any person insured by that insurer, the insurer need not pay any benefits to such owner until it has been fully indemnified for required loss benefits and claim processing costs incurred or which might be incurred pursuant to this subdivision.

(5) The insurance covering any motor vehicle involved in the accident if the victim is not an insured and is not occupying any motor vehicle.

(6) In the event no insurance is applicable under the above priorities, a person suffering personal injury shall claim benefits from the owner of any motor vehicle involved in the accident, which owner shall be liable as if an insurer in addition to any tort liability of such owner.

(b) Except as provided by a policy providing a modified form of coverage pursuant to Section 12011, every accident victim shall be eligible for required loss benefits without regard to fault, except for the following classes of victims:

(1) any person involved in a motor vehicle accident while voluntarily engaged in the use or occupancy of a motor vehicle known by him or her to be stolen or to be operated without the permission of its owner;

(2) any person involved in a motor vehicle accident while engaged in the use or occupancy of a motor vehicle owned by him or her (or by his or her spouse residing in the same household) with respect to which no motor vehicle insurance has been provided in accordance with Section 12002;

(3) any person involved in a motor vehicle accident while engaged in the use of a motor vehicle not owned by him or her (or by his or her spouse residing in the same household) for which no insurance has been provided in accordance with Section 12002 if such person

(i) would have been insured under an insurance policy constituting insurance for that vehicle had the owner of that vehicle obtained such a policy; and

(ii) is not an insured under a policy of insurance providing insurance for some other motor vehicle;

(4) any person who intentionally attempts to cause harm, to himself or herself or others, in a motor vehicle accident;

(5) any person who suffers injury while engaged in the use or occupancy of a motorized vehicle with three or fewer load bearing wheels; and

(6) any person who suffers injury while engaged in the commission of a felony.

(c) Only one insurer shall be liable to pay required loss benefits to a person suffering personal injury, except that all owners liable pursuant to priority (6) of subdivision (a) of this Section shall be jointly and severally liable for such benefits.

(d) A victim who is an insured under a policy providing for basic loss benefits in excess of required loss benefits may recover any additional benefits to which such victim is entitled from his or her own insurer.

(e) If two or more insurers are obligated at the same level of priority to pay benefits in accordance with the priorities set forth in subdivision (a) of this Section, the insurer against whom the claim is first made shall pay the claim as if wholly responsible, and may thereafter recover contribution pro rata from any other insurer at that priority level for the costs of the benefit payments. If contribution is sought under priority (4), (5), or (6) of subdivision (a) of this Section, pro ration shall be based on the number of motor vehicles involved.

(f) For purposes of this Section, a parked or unoccupied motor vehicle is not a motor vehicle involved in an accident unless it was so parked as to cause unreasonable risk of injury.

(g) Payment of benefits. (1) Timeliness. Basic loss benefits shall be payable when loss accrues. Loss accrues not when personal injury occurs but when medical expense or work loss is incurred or when death occurs. Benefits payable for accrued losses are not due until the insurer has received reasonable proof of the fact of the loss, the amount of the loss (including the reasonableness and necessity of any medical expenses and the duration of any disability), and the causation of the loss by the accident or until such proof would have been received had the insurer timely requested such proof after being notified of the accrual of the loss. If an insurer uses reasonable diligence to investigate whether a loss of whose accrual it has been notified is payable, reasonable proof of loss is complete only when the insurer has completed its investigation or has received information which demonstrates that further investigation is not reasonably necessary.

(g) (2) Interest on overdue payments. Subject to the provisions of subdivision (g)(3) of this Section and to Section 12014, such benefits are overdue if not paid within thirty days after completion of reasonable proof of the loss sustained in accordance with subdivision (g)(1), except that an insurer may accumulate claims for periods not exceeding one month, and benefits are not overdue if within twenty days after the period of accumulation. If reasonable proof is supplied as to the entire claim, the amount supported by reasonable p[illegible]s overdue if not paid within thirty days after such proof is complete. Any part of the remainder of the claim that is later supported by reasonable proof is overdue if not paid within thirty days after such proof is complete. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear interest at the rate of 18% per annum.

(g) (3) Suspension of benefits. Where an insurer has requested of a person receiving basic loss benefits that such person undergo medical treatment or medical rehabilitation services, and such person unreasonably refuses to comply with such request, the insurer may suspend all future basic loss benefits until such person complies with the request of the insurer, provided, however, that the insurer shall notify the person in writing whose benefits are suspended of its action and the basis thereof and shall maintain proof of its request and the victim's refusal to comply. It shall not be unreasonable for a person utilizing only non-medical care in accordance with a religious method of healing recognized by the laws of this State to refuse to undergo medical treatment to which such person conscientiously objects for religious reasons.

(h) (1) Any dispute between a victim and an insurer regarding the insurer's liability to pay basic loss benefits, the amount thereof, and any interest due thereon shall be submitted to arbitration pursuant to simplified procedures to be promulgated or approved by the Commissioner which procedures shall allow participation by the parties in the selection of the arbitrator. A decision by an arbitrator may be vacated or modified by a master arbitrator in accordance with simplified procedures to be promulgated or approved by the Commissioner and on such grounds as may be provided by such procedures. The decision of a master arbitrator shall be binding unless set aside by a court for fraud, corruption, bias or misconduct of the master arbitrator, or as exceeding the powers of the master arbitrator. An arbitrator or master arbitrator shall award the claimant reasonable attorneys' fees expended or incurred to obtain basic loss benefits which the arbitrator or master arbitrator finds to have been withheld or delayed without reasonable grounds. Such awards may exceed the limits set forth in Section 12019.

(h) (2) Benefits, interest, and attorneys' fees shall be the only amounts recoverable for any and all disputes relating to a claim for basic loss benefits, including, without limitation, delay in payment, and no other amounts sha[illegible] recoverable pursuant to any statute or to the common law, provided tha[illegible] proof that any payment has been delayed or denied by an insurer witho[illegible] substantial justification, the arbitrator may award, in addition to benefits, interest and attorneys' fees, treble the amount found to have been delayed or denied without any substantial justification and any other consequential economic damages determined by the arbitrator to have been sustained as a result of the unjustified delay or denial in payment. The proceedings specified by subdivisions

(h)(1) and (i)(2) of this Section shall be the sole methods of recovering such amounts.

(i) A victim's assignment or agreement to assign any basic loss benefits to become payable under this Chapter, for loss accruing in the future, is unenforceable except as to:

(1) Benefits for work loss assigned to secure payment of alimony, maintenance, or child support; and

(2) Benefits for medical expense to the extent that benefits are for the cost of products, services, or accommodations provided or to be provided by the assignee.

The assignee of a claim shall have no greater right to payment than would the victim had there been no assignment. A provider which accepts an assignment of medical expense benefits for products, services, or accommodations provided or to be provided to a victim shall not receive or demand any additional amount for such services from such victim except to the extent that payment of the reasonable value of or reasonable charges for such products, services, or accommodations as were reasonably necessary is prevented by exhaustion of the aggregate benefit limits or the time limits for furnishing covered products, services, or accommodations applicable under the insurance for such victim's benefits. Any dispute as to the reasonable charges for (or value of) or the reasonable necessity for products, services, or accommodations for which the provider accepted an assigned claim shall be resolved solely between such provider and the insurer denying payment for allegedly unreasonable amounts or unnecessary services, but such disputes are not subject to the arbitration provisions of subdivision (h). However, any action to resolve such a dispute must be commenced within the time allowed for the assignor of the claim to commence an arbitration proceeding, had the claim not been assigned, but in no event later than one year after the insurer has denied payments. If an insurer is found to have withheld or delayed payment on a claim assigned to a provider without reasonable grounds, the provider may recover, as costs of the proceeding, reasonable attorneys' fees (based upon actual time expended) incurred or expended to obtain the benefits which were withheld or delayed without reasonable grounds.

(j) Benefits for work loss are exempt from garnishment, attachment, execution, and any other process or claim to the extent that wages or earnings are exempt under any applicable law exempting wages or earnings from legal process or claims.

(k) If no basic loss benefits have been paid, an arbitration proceeding pursuant to subdivision (h) for basic loss benefits may be commenced not later than one year after the victim suffers the loss. If basic loss benefits have been paid for such loss, an arbitration proceeding pursuant to subdivision (h) for recovery of further benefits for such loss shall be commenced not later than one year after the last payment of benefits but in no event later than one year after death of the victim. The limitations periods prescribed in this Section shall govern all arbitration proceedings for benefits under this Chapter, notwithstanding any limitations prescribed elsewhere in the laws of this State.

12006. Interstate basis for insurance.

(a) The insurance required by this Chapter applies whenever an insured suffers personal injury occurring within the United States of America, its territories or possessions, or Canada.

(b) An insurance policy which purports to provide insurance or is sold with the representation that it fulfills the requirements of insurance as required by this Chapter is deemed to include all coverage required by this Chapter except to the extent that such coverage has been deleted or modified in accordance with this Chapter.

(c) Every insurer authorized to transact the business of providing insurance under this Chapter shall submit to the Commissioner of Insurance, as a condition of its continued transaction of such business within this State, a declaration that its motor vehicle insurance policies, providing protection against bodily injury liability, and issued with respect to any motor vehicle registered in the United States of America, its territories or possessions, or Canada, shall be deemed to provide the insurance required by this Chapter and to satisfy the requirements of the motor vehicle financial responsibility laws of this State when any insured vehicle is operated in this State. Any non-admitted insurer may file such a form. Such a declaration does not obligate the insurer to provide uninsured motorist coverage or any other coverage not necessary to establish financial responsibility under this Chapter and the motor vehicle financial responsibility laws of this State.

(d) In the event a person who suffers personal injury occurring in this State is entitled to basic loss or other first-party benefits under the insurance requirements of more than one state, such person shall elect to recover under the laws of any one such state and only the benefits payable to such person under the insurance requirements of that state shall be due to such person.

12007. Tort suits—preservation of right to sue for damages in certain circumstances.

(a) To the extent otherwise permitted by the tort law of this State, an accident victim (or the victim's legal representative) may recover for medical expenses, work loss or funeral expenses to the extent that the amounts of those losses exceed the weekly or aggregate limits on the amounts of such losses for which basic loss benefits are paid or payable or which would have been payable but for the exercise of a cost reducing option authorized by Section 12011.

(b) Any accident victim (or the legal representative of the victim) shall have the right to recover any damages in tort for medical expenses or work loss for which basic loss benefits are paid or payable or which would have been payable but for the exercise of a cost reducing option authorized by Section 12011. Any accident victim who is ineligible for basic loss benefits pursuant to Section 12005(b) has no right to recover any damages in tort for medical expenses or work loss for which such person would have been eligible for basic loss benefits had he or she not been disqualified by Section 12005(b). Work loss benefits of 80% of the work loss (after deduction of all federal and state taxes) suffered are the benefits recoverable for all of such work loss and no work loss for which such benefits have been paid or are payable shall be recoverable.

(c) No person shall recover non-economic loss for personal injury unless the injury to the victim giving rise to such non-economic loss:

(1) results in death,

(2) consists in whole or in part of a serious and permanent disfigurement, or

(3) is an injury which is both serious and permanent within a reasonable degree of medical probability. For purposes of this subparagraph (3), an injury is "serious" only if it has a substantial bearing on the injured person's ability to resume substantially all of his or her normal activities and life style and is "permanent" only if its effects cannot be eliminated by further time for recovery or by further medical treatment and care, including surgery.

(d) Nothing in this Section 12007 shall limit the right of any person to bring a tort action against:

(1) a person involved in a motor vehicle accident while voluntarily engaged in the use or occupancy of a motor vehicle known to him or her to be stolen, or to be operated without the permission of its owner;

(2) a person engaged in the use of a motor vehicle with respect to which no insurance has been provided in accordance with Section 12002 if such person would have been an insured under a policy of insurance constituting insurance for that vehicle had the owner of such vehicle been the named insured under such a policy;

(3) a person who intentionally attempted to cause harm in a motor vehicle accident;

(4) a person engaged in the use of a motorized vehicle with three or fewer load bearing wheels;

(5) a person who, as a result of committing any one of the following offenses, for which offense that person was convicted, caused harm in a motor vehicle accident:

(i) any felony;

(ii) Vehicle Code Sections 20001 or 20002 (hit and run driving);

(iii) Vehicle Code Sections 23152 or 23153 (driving under the influence of alcohol or other controlled substances).

(6) the owner of any vehicle for which insurance has not been provided in accordance with Section 12002 if such owner is legally responsible for the conduct of some other person engaged in the use of such vehicle, regardless of whether the person so engaged is protected by the limitations on recovery contained in subdivisions (a), (b) and (c) of this Section; for purposes of this subdivision (d) the term "owner" does not exclude the United States of America.

(e) The provisions of subdivisions (a), (b) and (c) of this Section do not apply in those instances where the person suffering personal injury is a person engaged in the use or occupancy of a motorized vehicle with three or fewer load bearing wheels, unless such person had failed to comply with any obligation to maintain insurance with respect to the use of such motorized vehicle imposed by the laws of this State.

(f) Nothing in this Section shall authorize or prohibit the recovery of punitive or exemplary damages from any person whose conduct in the use of a motor vehicle which causes personal injury warrants such an award under the laws of this State, but such punitive or exemplary damages shall not be paid or reimbursed by any insurer.

12008. Subrogation.

No insurer shall have a lien on any recovery in tort by judgment, settlement, or otherwise, or any right to recover from any person for basic loss benefits, whether suit has been filed or settlement has been reached without suit, except in those instances where a claimant is entitled to recover in tort for economic loss with respect to which basic loss benefits have been paid or are payable. Nothing in this Section shall prohibit any insurer from obtaining subrogation from any person who was convicted of a violation of Vehicle Code Section 23152 or Section 23153 (driving under the influence of alcohol or any controlled substance). Any subrogation recovery obtained by an insurer pursuant to the preceding sentence shall be first applied to reimburse the insured for any deductible amounts on any coverage borne by the insured with respect to the loss.

12009. Amount of work loss.

(a) In computing the amount of work loss of an accident victim who is disabled from working as a result of personal injury, it shall be presumed, absent a contrary showing, that such accident victim's income but for such disability during a given period prior to the victim's death would have been the product of

(1) the number of weeks in that period the victim probably would have worked had the victim not been disabled, and

(2) the victim's "probable weekly income if employed" as determined pursuant to this Section.

In no event shall any work loss be computed for any period in which the victim probably would not have worked even if not disabled.

(b) For purposes of subdivision (a)(2) of this Section, a victim's "probable weekly income if employed" shall be determined as follows:

(1) If a victim was regularly employed or self-employed or had been so employed in the prior three months at the time of the accident, the victim's "probable weekly income if employed" shall be the victim's probable annual income divided by 52. The victim's probable annual income shall be the greater of:

(i) twelve times the monthly gross income earned by the victim from work in the month preceding the month in which the accident resulting in personal injury occurred; or

(ii) the average income earned by the victim during the two calendar years preceding the year in which that accident occurred.

(2) If a victim was seasonally or irregularly employed as of the time of the accident causing personal injury, or had been unemployed for at least three

months but less than two years, the victim's "probable weekly income if employed" shall be the total gross income of the victim during the prior two years divided by the number of weeks in which the victim worked during that period.

(3) If a victim had not been remuneratively employed or self employed within the two years next preceding the accident causing personal injury, the victim's "probable weekly income if employed" shall be presumed to be zero, provided that the victim may rebut the presumption by proof that the victim would have been employed during the first year after the accident, and further provided, that the "probable weekly income if employed" shall be presumed not to exceed 80% of the average weekly gross income of a production or non-supervisory worker in the private non-farm economy in the state in which the victim was domiciled during the year preceding the year in which the accident occurred.

(4) If a victim is disabled from performing one or more but less than all duties of the victim's usual and customary occupation, the victim's work loss shall not include any portion of the victim's probable income but for the disability which the victim reasonably could earn despite the disability. However, if it is more reasonable for the victim to engage in available substitute work, then this limitation shall not apply, and the work loss shall instead be reduced with respect to the substitute work as provided in Section 12001(18).

12010. Source of benefits; net loss.

(a) Where an accident victim is entitled to benefits under any federal or state workers' compensation law for any medical expense incurred because of personal injury or to have his or her employer bear such expense connected with his or her employment without regard to the employer's fault, basic loss benefits shall not be payable for such medical expenses except to the extent that the workers' compensation benefits and employer payments fail to provide for payment of reasonable charges actually incurred for products, services, or accommodations for which basic loss benefits would otherwise be payable. Only those medical expenses actually paid or reimbursed by basic loss benefits shall be considered in determining whether the aggregate limit on payment of basic loss benefits for medical expenses has been reached.

(b) All benefits paid or payable under any state or federal workers' compensation law or any state or federal occupational or non-occupational disability law (including Social Security) on account of disability produced by personal injury shall be deducted from the basic loss benefits otherwise payable for work loss during the same period on account of that same disability, and no basic loss benefits for work loss shall be payable if such other benefits payable for the same period equal or exceed the benefits otherwise payable for work loss during that period.

12011. Options to reduce premium costs.

(a) Insurers may offer modified forms of the coverages required by Section 12003 which enable purchasers of insurance to reduce their premium costs by eliminating unwanted, unnecessary or duplicate insurance coverage. Examples of such modified forms of coverage include, but are not limited to, provisions that those insured under the policy (i) would limit or forego required loss benefits which would duplicate benefits available under other insurance or income continuation plans, (ii) would limit or forego required loss benefits for medical care which would be provided without charge pursuant to any agreement with a Health Maintenance Organization or similar entity, (iii) would limit or forego (through deductibles or waiting periods) required loss benefits for smaller losses (provided that the deductible for medical expense shall not exceed $2,000 per person and all policies shall provide at least $5,000 per person in coverage for medical expense in excess of the stated deductible), (iv) would limit or forego the weekly required loss benefits payable for work loss to reflect the lack of any earnings by one or more insureds or earnings insufficient to require payment of the maximum benefit amounts specified in Section 12003(b), or (v) would accept medical and medical rehabilitation services in kind from providers of such services engaged by the insurer in lieu of medical expense benefits for such services. The insurer shall provide an appropriate agreed reduction in premium for any policy containing any such modified form of coverage.

(b) Any reduction in or modification of the coverage for required loss benefits shall apply only to insureds under the policy and not to other victims for whom the policy constitutes insurance for required loss benefits.

(c) Any agreement to accept such a modified form of coverage must be made in writing by a named insured under the policy. Any such agreement by any named insured shall be binding on every insured to whom the policy applies while the policy is in force, and shall continue to be so binding with respect to any continuation or renewal of the policy or with respect to any other policy which extends, changes, supersedes, or replaces the policy issued to the same named insured by the same insurer, or with respect to reinstatement of the policy within 30 days of any lapse thereof.

(d) No such modified coverage shall be offered without giving the named insured the option to purchase the unmodified coverages as specified in Section 12003. Any agreement to accept modified coverage (1) shall recite that it provides for a coverage modification, (2) shall describe the benefit reductions resulting from that modification, (3) shall state that the named insured need not accept that modification to the coverage and may purchase unmodified coverage without the premium reduction given for such modification, and (4) shall be signed by a named insured. At or before the time a named insured enters into such an agreement, the insured shall be given written notice indicating the approximate amount or magnitude of the premium reduction provided on account of such modification. Any agreement to modify coverage complying with this Section shall be conclusively deemed to be valid and binding unless set aside for fraud or mutual mistake.

(e) At the request of any insurer desiring to offer a particular form of modified coverage, the Commissioner shall provide a ruling on whether a specified form of agreement satisfies the requirements of this Section and, if not, the respects in which it fails to do so. Nothing herein shall prevent an insurer from using a form not subject to such a ruling.

12012. Supervision—penalties.

(a) The Commissioner shall regularly and systematically monitor the operation of every insurer providing the insurance required under Section 12002 of this Chapter to assure that such insurers are in compliance with this Chapter.

(b) If, as a result of such review, the Commissioner finds that an insurer violation of this Chapter, with such frequency that the conduct of the insurer in violation of the Chapter amounts to a regular and ongoing business practice, he or she may, after hearing, assess a fine against such insurer in an amount not less than $1,000 nor more than $50,000, unless he or she finds that the insurer reasonably believed that its conduct was lawful.

(c) If the Commissioner finds that a regular and ongoing business practice violative of this Chapter was (1) committed by an insurer with knowledge on the part of managerial personnel of its illegality or with deliberate and reckless disregard for whether it was legal and (2) designed specifically to deny benefits to eligible victims under this Chapter, he or she may, after hearing, suspend or revoke the insurer's license to do business in this State.

(d) Except as set forth in Section 12005(h)(2), no insurer to which the penalty provisions of this Section apply, nor any officer, director, employee, or agent thereof, shall be subject to punitive or exemplary damages for any claim arising out of allegedly improper handling of any application for basic loss benefits, or any act or omission of such insurer, or any officer, director, employee, or agent thereof, in adjusting any claim for such benefits.

12013. Procedures for Liability Claims and Tort Actions.

(a) No accident victim shall make, directly or through any representative, any demand to settle any claim for damages for personal injury on any insurer which includes any amount for non-economic loss unless such accident victim or a representative first complies with the following procedures. A victim desiring to make such a demand shall offer in writing to the insurer to which the demand will be addressed an opportunity to conduct an independent medical examination of the victim. Within fifteen days of receipt of such offer to conduct an independent medical examination, the insurer shall either (i) designate in writing a date, time and place for such examination or (ii) state in writing that it waives the opportunity to conduct such examination. The date designated for such examination shall be at least ten days but no later than thirty days after the date of mailing to the accident victim (or legal representative) the written designation of the date, time and place for such examination. A demand to settle a claim for damages for personal injury which includes an amount for non-economic loss may be made (i) at any time after receipt from the insurer of a notice that it waives the opportunity to conduct such examination or (ii) fifteen days after such examination. An insurer shall have no duty to consider any settlement demand made in violation of this Section, and any settlement demand made in violation of this Section shall not be admissible in any action for any purpose.

(b) If any person who suffered personal injury brings an action to recover non-economic losses arising out of that accident, such person may neither plead nor prove the amount of any losses for which basic loss benefits were paid or are payable in his or her action to recover non-economic losses. The court shall instruct the jury that, in arriving at a verdict as to the amount of damages for non-economic losses recoverable by such a person, the jury shall not speculate as to the amount of any medical expenses or other losses not proven in the action or consider such expenses or other losses.

(c) Pretrial threshold determination. In any action where the defendant contends that the plaintiff's injury does not meet the requirements of Section 12007(c), either party may seek summary judgment on that issue. If such a motion is made, the court must determine at least 30 days before the date set for trial whether there is any material issue of fact as to whether those requirements have been met and, if not, render summary judgment in accordance with the undisputed facts. If the facts regarding the nature of the injury or disfigurement and its effect on the plaintiff are undisputed, the question of whether those effects render the injury or disfigurement serious and permanent, within the meaning of Section 12007(c), is a question of law to be decided by the court. If the court renders summary judgment on this issue and finds that the party against whom such summary judgment is rendered had no reasonable basis for its position as to whether the requirements of Section 12007(c) had been met, the court shall assess against such party the reasonable costs and attorneys' fees (based upon actual time expended) incurred or expended by the other party to obtain a determination on that issue.

(d) Bifurcated jury trial of threshold determination. In any action tried to a jury where the defendant contends that plaintiff's injury does not meet the requirements of Section 12007(c) but the defendant concedes or the court determines that there is a material issue of fact as to whether those requirements have been met, then, upon motion of the defendant, that issue shall be separately tried and no other evidence as to the plaintiff's damages shall be received until that issue has been resolved. After resolution of that issue, the amount of the plaintiff's damages may be tried before the same jury or a different jury, as the court may in its discretion decide.

(e) Until it has been determined in such action that a plaintiff has met the requirements of Section 12007(c), a liability insurer is not obligated to consider or settle any claim of that plaintiff for non-economic losses unless it has admitted to such plaintiff or to the court that the plaintiff has met those requirements, provided that nothing in this subdivision shall affect the obligation to consider or settle any claim after such determination has been made.

(f) Non-joinder of insurers. No motor vehicle liability insurer shall be joined as a party defendant in an action to determine the insured's liability.

12014. Discovery of facts about an injured person.

(a) Every employer shall, if a request is made by an insurer providing basic loss benefits under this Chapter against whom a claim has been made, furnish

forthwith, in a form approved by the Department of Insurance, a sworn statement of the earnings since the time of the personal injury and for a reasonable period before the injury of the person upon whose injury the claim is based. The sworn statement shall state: "Under penalty of perjury I declare that I have read the foregoing and the facts stated are true to the best of my knowledge and belief." To facilitate the insurer's investigation of these matters, every person claiming basic loss benefits shall, upon request by the insurer, execute a written authorization for release of such information.

(b) Every physician, hospital, clinic, or other medical institution providing (before or after a personal injury upon which a claim for basic loss benefits is based) any products, services, or accommodations in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, shall, if requested to do so by the insurer against whom the claim has been made, furnish a written report of the history, condition, prognosis, disability, dates of disability, treatment, and dates and costs of such treatment of the injured person, together with a sworn statement that the treatment or services rendered were reasonable and necessary with respect to the injury sustained and identifying which portion of the expenses for said treatment or services was incurred as a result of such injury and which portion of any disability resulted from such injury, and produce forthwith and permit the inspection and copying of his/her or its records regarding such history, condition, disability, dates of disability, treatment, and dates and costs of treatment. The sworn statement shall state: "Under penalty of perjury I declare that I have read the foregoing and the facts stated are true to the best of my knowledge and belief." No cause of action for violation of physician/patient privilege shall arise against any physician, hospital, clinic, or other medical institution complying with the provisions of this Section. The person requesting such records and said sworn statement shall pay all reasonable costs connected therewith. To facilitate the insurer's investigation of these matters, every person claiming basic loss benefits shall, upon request by the insurer, execute a written authorization for release of such information.

(c) In the event of any dispute regarding an insurer's right to discovery of facts about an injured person's earnings or about his or her history, condition, prognosis, disability, dates of disability, treatment, and dates and costs of such treatment, the insurer may petition a court of competent jurisdiction to enter an order compelling such discovery, which shall be granted where good cause is shown. Notice of such a motion shall be given to all persons having an interest and the petition shall be heard as expeditiously as possible. Any order shall specify the time, place, manner, conditions, and scope of the discovery. Discovery may be denied or may be permitted only upon conditions where necessary to protect against unwarranted annoyance or embarrassment, oppression, or as justice requires. The prevailing party on such a petition shall be awarded payment of its reasonable costs and expenses of the proceeding, including reasonable fees for the attendance of attorneys at the proceedings, unless the court determines that the opposing party's making of or opposition to the motion was substantially justified.

(d) The victim shall be furnished, upon request, a copy of all information obtained by the insurer under the provisions of this Section, and shall pay a reasonable charge, if required by the insurer.

(e) Notice to an insurer of the existence of a claim shall not be unreasonably withheld by a victim.

(f) Where an insurer has requested of a claimant that he/she submit himself/herself to an independent medical examination, said claimant must present himself/herself for such examination at a reasonable location and within a reasonable time after said request is made. In the event the claimant refuses to comply with an insurer's reasonable request for a medical examination, the insurer may deny all future claims for first-party benefits for personal injury (including, but not limited to, basic loss benefits) under any policy of motor vehicle insurance made by or on behalf of the claimant with respect to the same accident.

(g) Exchange of information. Where a third-party liability claim has been made against an insurer, or where the insurer has reason to believe that such a claim will be made, the insurer, upon request, may obtain all pertinent information submitted to any insurer obligated to pay first-party benefits to the claimant under any policy of motor vehicle insurance.

12015. Stacking of coverages prohibited.

If an insured or named insured is protected by any type of insurance pursuant to this Chapter or any type of motor vehicle insurance policy for liability, uninsured motorist, basic loss benefits, or any other coverage, the insurance shall provide that any insured or named insured is protected only to the extent of the coverage provided on the vehicle involved in the accident; however, if none of the vehicles covered by the policies applicable to the insured or named insured is involved in the accident, coverage is available (if provided by the policy) only to the extent of coverage on any one of the vehicles (to be selected by the insured) with applicable coverage. Coverage on any other vehicles shall not be added to or stacked upon that coverage. The foregoing provisions of this Section shall not apply to the extent that any policy of insurance expressly declares that it applies to losses in excess of those covered under other policies of insurance but the coverage provided by such insurance shall not exceed that specified by its terms. For purposes of this Section, the meaning of the term "insurance" is not restricted to that specified in Section 12001(5).

12016. No penalties for use of basic loss benefits.

No insurer shall cancel, refuse to renew, or increase the rate charged for any insurance policy solely on account of any prior payment of basic loss benefits to the insured or applicant.

12017. Uninsured and Underinsured Motorist Insurance.

In any policy affording insurance required by law to be purchased or offered providing for payment of sums which a person insured under that policy would be legally entitled to recover from the owner or operator of an uninsured or underinsured motorized vehicle, the amount which such person would be legally entitled to recover from such owner or operator shall be determined in accordance with subdivisions (a) and (b) of Section 12007 as if such vehicle were a motor vehicle covered by applicable insurance, except that if the victim injured by such uninsured or underinsured motor vehicle would be exempt from the operation of subdivisions (a) and (b) of Section 12007 pursuant to subdivision (d) of Section 12007, then subdivisions (a) and (b) of Section 12007 shall be disregarded in determining the amount recoverable. In no event shall the benefits payable under uninsured or underinsured motorist coverage required by law to be purchased or offered include any amounts which the insured would be entitled to recover as punitive or exemplary damages or any amounts for which the owner or operator of such vehicle would not have been liable had such owner or operator maintained insurance in accordance with this Chapter. Nothing in the foregoing provisions of this Section shall prevent any insurer from agreeing to provide coverage for losses whose payment is excluded by those provisions but such coverage may be provided only pursuant to an express agreement in writing.

12018. Initial premium charges.

(a) During the first two years following the effective date of the California Guaranteed Protection Plan, no insurer may establish or use statewide average premium rates for the New Insurance Package which, as of the effective date of such premium rates, are more than 80% of the statewide average premium rates for the Old Insurance Package.

(b) For purposes of this Section, the statewide average premium rates for the "Old Insurance Package" shall consist of the sum of the statewide average premium rates under that insurer's rating system in effect for new business issued on the day this Chapter is adopted for each of the following coverages:

(1) bodily injury liability coverage with limits of liability for any one accident of $15,000 for all damages arising from bodily injuries to any one person and $30,000 for all damages arising from bodily injuries to two or more persons;

(2) uninsured motorist coverage with similar limits; and

(3) primary automobile medical payments coverage with a limit of liability of $5,000 for all medical payments (without deductible, coinsurance or co-payments) by any one person as a result of any one accident irrespective of other medical coverage.

(c) For purposes of this Section, statewide average premium rates for the "New Insurance Package" shall consist of the sum of the statewide average premium rates for the insurer for the following coverages:

(1) bodily injury liability coverage and uninsured motorist coverage with the same limits as in the Old Insurance Package; and

(2) coverage for required loss benefits pursuant to Section 12003.

(d) The premium charged, either before or after adoption of this Chapter, for coverage for property damage liability shall be disregarded for purposes of this Section, despite any requirement that such coverage be included in the insurance policy issued.

(e) The California Automobile Assigned Risk Plan shall adopt a rating system providing premium reductions from the rates provided by it as of the date this Chapter is adopted comparable to those required by this Chapter for the rating systems established by or on behalf of individual insurers.

(f) The Commissioner of Insurance shall have exclusive jurisdiction, subject to judicial review, to administer and enforce this Section. The Commissioner may require insurers to provide appropriate information about their rating systems in effect at the time this Chapter is adopted and/or at any time within two years after it takes effect. If the Commissioner finds, after appropriate hearings, that any insurer has failed to comply with this Section, he or she may order such insurer to adopt rates in compliance with this Section and to provide an appropriate remedy for any charges in excess of those permitted by this Section.

12019. Attorneys' Contingency Fees.

(a) An attorney shall not contract for or collect a contingency fee for representing any accident victim as defined in subdivision (1) of Section 12001 (or legal representative of any accident victim) seeking basic loss benefits and/or damages in connection with any arbitration proceeding or civil action in excess of the following limits:

(1) Fifteen percent of any basic loss benefits recovered, regardless of amount;

(2) Thirty-three and one-third percent of the first fifty thousand dollars ($50,000) of damages recovered other than basic loss benefits;

(3) Twenty-five percent of the next fifty thousand dollars ($50,000) of damages recovered other than basic loss benefits;

(4) Fifteen percent of any amount by which the amount of damages recovered other than basic loss benefits exceeds one hundred thousand dollars ($100,000).

(b) These limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant or a person of unsound mind.

(c) If periodic payments are awarded to the plaintiff, a total present value shall be placed on these payments based upon the projected life expectancy of the plaintiff and this amount shall be included in computing the total award from which attorney's fees are calculated under this Section.

(d) For purposes of this Section, "recovered" means the net sum recovered after deducting any disbursements or costs in connection with prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office overhead costs or charges are not deductible disbursements or costs for such purpose.

12020. Severability.

If any provision of this Chapter or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the Chapter which can be given effect without the invalid provision or application, and to this end the provisions of this Chapter are declared severable, provided, however, that invalidity of the provisions of Section 12007 shall render this Chapter inoperative.

12021. Effective date.

(a) This Chapter shall take effect on July 1, 1989, shall be effective as to personal injury occurring on or after July 1, 1989, and shall govern policies of insurance in effect on and after that date.

(b) Effective on July 1, 1989, any insurance policy insuring a motor vehicle registered in this State and sufficient to satisfy the financial responsibility requirements of the laws of this State in effect at the time this Chapter is adopted shall be deemed amended to provide the coverages necessary for such policy to constitute insurance pursuant to this Chapter. The insurer shall determine any premium change resulting from such amendment for the remaining portion of the policy period and shall refund any amount due to the policyholder within 90 days after that date. However, if, prior to the expiration of such 90 day period, any payment becomes due under any premium payment plan or any named insured requests that the policy be altered, renewed, extended, or replaced in a way which calls for an increased premium, any amount due to the policyholder as a result of the amendment may be credited against any such premium payment or increased premium rather than being refunded.

SECTION 5. Section 11622 of the Insurance Code is amended to read as follows:

11622. *Required Coverage.*

Such plan shall require the issuance of a policy affording *coverage for required loss benefits and* coverage in the amount of fifteen thousand dollars ($15,000) for bodily injury to or death of each person as a result of any one accident and, subject to said limit as to one person, the amount of thirty thousand dollars ($30,000) for bodily injury to or death of all persons as a result of any one accident, and the amount of five thousand dollars ($5,000) for damage to property of others as a result of any one accident, or in such minimum amounts as are necessary to provide exemption from the security requirements of Section 16023 of the Vehicle Code or for which proof of ability to respond in damages or adequate protection against liability is otherwise required by law, but shall not require the issuance of a policy affording coverage in excess of said amounts.

SECTION 6. Section 11624 of the Insurance Code is amended to add a new subdivision (f) as follows:

11624. *Requirements of Plan.*

~~The~~ *Such* plan shall contain:

. . .

(f) Provisions specifying what modified forms of coverage, if any, shall be made available pursuant to Section 12011.

~~(f)~~ ~~Any~~ *(g) Such* other provisions as may be necessary to carry out the purpose of this article.

SECTION 7. Division 3, Article 5 of the Insurance Code is amended as follows:

Article 5. ~~Bureau of Fraudulent Claims~~ *Investigation and Prosecution of Insurance Fraud*

12990. *Bureau of Fraudulent Claims.*

~~There is created within the department a Bureau of Fraudulent Claims to enforce the provisions of Section 556.~~

There shall be a Bureau of Fraudulent Claims which shall fall under the authority and supervision of the Commissioner of Insurance.

12991. *Investigation of Fraudulent Claims.*

(a) If by its own inquiries or as a result of complaints, the Bureau of Fraudulent Claims has reason to believe that a person has engaged in, or is engaging in, an act or practice ~~that violates Section 556~~ *that violates any criminal statute of this state relating to the presentation or preparation of fraudulent insurance claims*, the ~~commissioner~~ *Commissioner* in his *or her* discretion (1) may make such public or private investigations within or outside of this state as he *or she* deems necessary to determine whether any person has violated or is about to violate any provision of ~~Section 556, or to~~ *such criminal statute or to otherwise* aid in the enforcement of this law, and (2) may publish information concerning any violation of this law.

(b) For purposes of any investigation under this law, the ~~commissioner~~ *Commissioner* or any officer designated by him *or her* may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require ~~the~~ production of any books, papers, correspondence, memoranda, agreements, or other documents or records which the ~~commissioner~~ *Commissioner* deems relevant or material to the inquiry; ~~as provided by the provisions of Section 12924~~.

(c) If matter that the ~~commissioner~~ *Commissioner* seeks to obtain by request is located outside the state, the person so requested may make it available to the ~~commissioner~~ *Commissioner* or his *or her* representative to be examined at the place where it is located. The ~~commissioner~~ *Commissioner* may designate representatives including officials of the state in which ~~the~~ *a* matter is located, to inspect the matter on his *or her* behalf, and he *or she* may respond to similar requests from officials of other states.

(d) Except as provided in subdivision (e), the department's papers, documents, reports or evidence relative to the subject of an investigation under this ~~section~~ *Section* shall not be subject to public inspection for so long a period as the ~~commissioner~~ *Commissioner* deems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to serve the public interest. Furthermore, such papers, documents, reports or evidence shall not be subject to subpoena or subpoena duces tecum until opened for public inspection by the ~~commissioner~~ *Commissioner*, unless the ~~commissioner~~ *Commissioner* otherwise consents or, after notice to the ~~commissioner~~ *Commissioner* and a hearing, the superior court determines that the public interest in any ~~ongoing~~ *on-going* investigation by the ~~commissioner~~ *Commissioner* would not be unnecessarily jeopardized by obeyance of such ~~a~~ subpoena or *a* subpoena duces tecum.

(e) The Bureau of Fraudulent Claims shall furnish all papers, documents, reports, complaints, or other facts or evidence to any police, sheriff or other law enforcement agency, when so requested, and will assist and cooperate with such law enforcement agencies.

12992. *Reporting of Fraudulent Claims.*

(a) Any company licensed to write insurance in this state which believes that a fraudulent claim is being made shall, within 60 days after determination by the insurer that the claim appears to be a fraudulent claim, send to the Bureau of Fraudulent Claims, on a form prescribed by the department, the information requested by the form ~~and~~ *in* such additional information relative to the fa[illegible] circumstances of the claim and the parties claiming loss or damages ~~commissioner~~ *Commissioner* may require. The Bureau of Fraudulent Clai[illegible] shall review each report and undertake such further investigation as it deems necessary and proper to determine the validity of the allegations. Whenever the ~~commissioner~~ *Commissioner* is satisfied that fraud, deceit, or intentional misrepresentation of any kind has been committed in the submission of the claim, he *or she* shall report any such violations of law to the insurer, to the appropriate licensing agency and *to* the district attorney of the county in which such offenses were committed; ~~as provided by the provisions of Sections 12928 and 12930~~. If the ~~commissioner~~ *Commissioner* is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, he *or she* shall report such determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the ~~commissioner's~~ *Commissioner's* report, the district attorney shall inform the ~~commissioner~~ *Commissioner* and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

(b) This ~~section~~ *Section* shall not require an insurer to submit to the bureau the information specified in subdivision (a) in either of the following:

(1) The insurer's initial investigation indicated a potentially fraudulent claim but which further investigation revealed not to be fraudulent.

(2) The insurer and the claimant have reached *an* agreement as to the amount of the claim and the insurer does not have reasonable grounds to believe the claim to be fraudulent.

(c) Nothing contained in this ~~article~~ *Article* shall relieve an insurer of its existing obligations to also report suspected violations of law to appropriate local law enforcement agencies.

(d) Any police, sheriff or other law enforcement agency shall furnish all papers, documents, reports, complaints, or other facts or evidence to the Bureau of Fraudulent Claims, when so requested, and shall otherwise assist and cooperate with the bureau.

12993. *Immunity from Liability for Reporting.*

No insurer, or the employees or agents of any insurer, shall be subject to civil liability for libel, slander or any other relevant tort cause of action by virtue of ~~the~~ filing of reports, without malice, or furnishing other information, without malice, required by this ~~article~~ *Article* or required by the ~~commissioner~~ *Commissioner* under the authority granted in this ~~article~~ *Article*.

12994. *Prosecution of Fraudulent Claims.*

Nothing contained in this ~~article~~ *Article* shall preempt the authority of local law enforcement agencies to investigate and prosecute suspected violations of law[illegible] shall it relieve them of their duty to do so. *However, if the district attorney[illegible] the Commissioner, pursuant to Section 12992 that he or she chooses not to [illegible]ute a violation reported to him or her by the Commissioner, then the Commissioner may direct the Bureau of Fraudulent Claims to prosecute such violation.*

12995. *Funding of Bureau.*

The costs of administration and operation of the Bureau of Fraudulent Claims shall be borne by all of the insurers admitted to transact insurance in this state. The ~~commissioner~~ *Commissioner* shall divide such costs among all such companies, assessing each such company an identical amount adequate to provide the ~~funds~~ *total cost* ~~for~~ *of* each fiscal year of *the* operation of the ~~bureau~~ *Bureau*; provided, however, the assessment for each company shall not exceed one thousand dollars ($1,000) in each fiscal year. All moneys received by the ~~commissioner from insurers~~ *Commissioner* pursuant to this ~~section~~ *Section* shall be transmitted to the State Treasurer to be deposited in the State Treasury to the credit of the Insurance *Commissioner's Regulatory Trust* Fund, *which shall be created for this purpose.* All moneys ~~which are deposited~~ in the *such* fund ~~after receipt by~~ *received from* the commissioner ~~from insurers~~ pursuant to this section are hereby appropriated to the department and are to be exclusively used for the support of the Bureau of Fraudulent Claims. ~~To the extent the assessments against insurers made pursuant to this section are not sufficient to fund the entire operations of the bureau, other money appropriated to the department, if available, may be used, in the commissioner's discretion, to fund those operations not covered by the assessments.~~ The total budget of the ~~bureau~~ *Bureau* shall be as determined annually in the Budget Act, *which may make additional appropriations to the Bureau if the maximum assessment permitted by law has already been levied on insurers.*

SECTION 8. Section 12924.5 is added to the Insurance Code as follows:

12924.5. Consumers' rights to present evidence.

(a) In any proceeding before the commissioner, any person or organization may present written or oral evidence, subject to such rules and regulations that may be established by the commissioner, provided that nothing herein shall create a right of any person or organization to intervene in any proceeding.

(b) Any person or organization, whether a party, intervenor, witness or other participant in any proceeding before the commissioner, shall bear its own costs and attorney's fees. No state funds or award against any other person or organization shall be used to reimburse the costs or attorney's fees incurred by any party or participant in any such proceeding.

SECTION 9. Sections 790.03.1 and 790.03.2 of the Insurance Code are added as follows:

790.03.1. Procedures to Resolve Claims under Policies of Liability In[illegible]

(a) Any claimant who has submitted a claim to any insurer under a [illegible]cy of liability insurance may, at any time after submitting the claim, serve upon the insurer a Demand to Resolve Claim.

(b) A Demand to Resolve Claim shall be in writing, shall state that it is a Demand to Resolve Claim under Insurance Code Section 790.03.1, and shall set forth a specific dollar amount within policy limits which the claimant offers to

accept in full settlement of the claim of the claimant against the person or persons insured under the policy of liability insurance.

(c) If the insurer, within thirty days of receipt of a Demand to Resolve Claim, tenders the amount specified therein to the claimant, the claimant shall have no right to maintain a private civil action for violation of Section 790.03(h) with respect to the claim.

(d) If the insurer, within thirty days of receipt of a Demand to Resolve Claim, reaches a written agreement with the claimant in settlement of the claim, the claimant shall have no right to maintain a private civil action for violation of Section 790.03(h) with respect to the claim.

(e) If the insurer, within thirty days of receipt of a Demand to Resolve Claim, offers in writing to submit the claim to binding arbitration under Section 790.03.2, the claimant shall have no right to maintain a private civil action for violation of Section 790.03(h) with respect to the claim. This subdivision shall apply whether or not the claimant accepts the offer to submit the claim to binding arbitration.

(f) The time limits set forth in subdivisions (c), (d) and (e) of this Section shall be increased to ninety days if the Demand to Resolve Claim is served prior to sixty days after the date the claim was first submitted to the insurer.

(g) No claimant may maintain a private civil action for violation of Section 790.03(h) which relates in any way to any claim made under any policy of liability insurance unless that claimant has, at least ninety days prior to the commencement of the action, served upon the insurer a Demand to Resolve Claim. Unless there is a dispute as to whether an insurer received a Demand to Resolve Claim or a dispute as to whether an insurer offered to submit the claim to binding arbitration, the fact that an insurer received a Demand to Resolve Claim and the manner in which an insurer responded to any Demand to Resolve Claim shall not be admissible in evidence in any private civil action to prove a violation of Section 790.03(h).

(h) Nothing in this Section shall be deemed to expand or limit in any way the right of any person to maintain a private civil action for violation of Section 790.03(h) with respect to any first-party claim made under any policy which provides insurance to that person.

790.03.2. Procedures for Binding Arbitration of Claims Under Policies of Liability Insurance.

(a) An insurer who receives a Demand to Resolve Claim from a claimant under any policy of liability insurance may, within the time allowed by Section 790.03.1, serve on the claimant an offer to submit the claim to binding arbitration under this Section.

(b) The claimant shall, within thirty days after receipt of such offer to submit the claim to binding arbitration, serve on the insurer a notice either accepting or rejecting the offer to submit the claim to binding arbitration. Failure by the claimant to respond within the time specified shall be deemed to constitute a rejection of the offer to submit the claim to binding arbitration.

(c) No later than twenty calendar days after the date of service of a notice accepting an offer to submit a claim to binding arbitration, each party shall select a referee and shall serve upon the other party a notice designating the name, address and telephone number of said referee.

(d) Within thirty days after the service of the last notice designating a referee, the referees so designated shall meet and confer, in person or by telephone, and agree upon the appointment of a neutral arbitrator. If they fail to agree upon the appointment of a neutral arbitrator within the time specified, any party may petition a superior court to designate an odd-numbered list of neutral arbitrators. The parties shall then either agree on a neutral arbitrator or shall select a neutral arbitrator from the list by the claimant first striking a name, the insurer then striking a name, and proceeding to strike names alternately until only one name remains. That person shall be the neutral arbitrator. The referees shall not participate in the arbitration proceeding after selection of the neutral arbitrator except to select another neutral arbitrator in the event the arbitrator selected cannot serve for any reason.

(e) The neutral arbitrator so selected shall proceed to arbitrate the claim. Unless the parties agree in writing otherwise, the neutral arbitrator shall be informed of the applicable policy limits but shall not be informed of settlement offers and demands, including the amount set forth in the Demand to Resolve Claim, until the initial award. The arbitration hearing shall commence within ninety days of the selection of the neutral arbitrator and the taking of evidence shall be concluded no later than thirty calendar days after the date of commencement, regardless of the number of actual hearing days held.

(f) When an insurer makes an offer to arbitrate under Section 790.03.2(a) and the offer is accepted by the claimant, the insurer shall be deemed to have waived the right to assert a lack of coverage in the arbitration and as a basis for not paying any part or all of the final arbitration award. Nothing in this subdivision shall be deemed to impair or prejudice an insurer's right to seek a determination in any court of competent jurisdiction of its coverage obligations relative to its insured.

(g) The arbitration proceeding, including any discovery pertaining thereto, shall be conducted in accordance with and be governed by Sections 1280 to 1288.2 of the Code of Civil Procedure except as specified in this Section.

(h) Upon request of either side, a record shall be made of the arbitration hearing.

(i) The neutral arbitrator shall issue an initial award in writing within thirty days after the conclusion of the taking of evidence. The amount of the initial award (exclusive of costs, expert witness fees and attorney's fees) shall not exceed the limit of the policy of insurance applicable to the claim.

(j) The neutral arbitrator shall retain jurisdiction for thirty days after the issuance of the initial award to receive and determine a request for an award of attorney's fees and expert witness fees.

(k) Within ten days after the issuance of an initial award, the claimant may submit to the neutral arbitrator and serve on the insurer a request for an award of attorney's fees and expert witness fees. The insurer shall have ten days to submit to the neutral arbitrator and serve on the claimant its response to the request for attorney's fees and expert witness fees. The claimant shall be entitled to an award of reasonable attorney's fees and reasonable expert witness fees incurred after service of the Demand to Resolve Claim but before the commencement of the arbitration hearing only if the amount of the initial award exceeds the highest amount offered by the insurer to the claimant at any time prior to the selection of the neutral arbitrator. The claimant shall be entitled to an award of reasonable attorney's fees and reasonable expert witness fees incurred after the commencement of the arbitration hearing only if the amount of the initial award exceeds the highest amount offered by the insurer to the claimant at any time prior to the commencement of the arbitration hearing. In no case shall the combined amount of attorney's fees and expert witness fees awarded exceed the amount of the initial award.

(l) Within thirty days after the issuance of the initial award, the neutral arbitrator shall enter a final award, including any amount awarded for attorney's fees and expert witness fees.

(m) The expenses and fees of the neutral arbitrator, together with other expenses incurred or approved by the neutral arbitrator, not including attorney's fees or expert witness fees, shall be paid in all cases by the insurer. The claimant's referee's fees shall not exceed $250.

(n) Payment by an insurer of any arbitration award issued hereunder, or of a judgment confirming any such award, shall discharge any and all liability to the claimant of the person or persons insured under the policy of insurance under which the claim was made.

(o) The parties may agree in writing on any alternative arbitration procedure allowable by law including, without limitation, different time requirements, conducting the proceeding before more than one neutral arbitrator, different provisions regarding costs and attorney's fees, or different procedures for selection of a neutral arbitrator or arbitrators.

SECTION 10. Sections 679.70, 679.71 and 790.03(f) of the Insurance Code are reenacted as follows:

679.70. *Application of chapter; certain property and liability insurance; exceptions.*

This chapter shall apply to policies of insurance, other than automobile insurance and workmen's compensation insurance, on risks located or resident in this state which are issued and take effect or which are renewed after the effective date of this chapter and which insure any of the following contingencies:

(a) Loss of or damage to real property which is used predominantly for residential purposes.

(b) Loss of or damage to personal property in which natural persons resident in specifically described real property of the kind described in subdivision (a) have an insurable interest.

(c) Legal liability of a natural person or persons for loss of, damage to, or injury to, persons or property.

679.71. *Failure or refusal to accept application for, issue or cancel insurance based on marital status, sex, race, color, religion, national origin or ancestry.*

No admitted insurer, licensed to issue any policy of insurance covered by this chapter, shall fail or refuse to accept an application for, or to issue a policy to an applicant for, such insurance (unless such insurance is to be issued to the applicant by another insurer under the same management and control), or cancel such insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every marital status, sex, race, color, religion, national origin, or ancestry; nor shall sex, race, color, religion, national origin, or ancestry of itself constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for such insurance.

790.03. *Prohibited acts.*

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

. . .

(f) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if such differentials are substantially supported by valid pertinent data segregated by sex, including, but not necessarily limited to, mortality data segregated by sex.

However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of such differentials based on data segregated by sex, rates or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (a) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (b) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. "Compliance date" as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.5 and 10489.2 or successor sections.

Notwithstanding the provisions of this subdivision, sex based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (1) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as such terms are used in Title VII of the Civil Rights Act of 1964, as amended, and (2) tax sheltered annuities for employees of public schools or of tax exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

SECTION 11. Section 40000.26 of the Vehicle Code is added as follows:

40000.26. Misdemeanors

A violation of the following provision is a misdemeanor, and not an infraction: Section 16050 (concerning a second or subsequent conviction of an offense relating to proof of financial responsibility by every driver or employer involved in an accident).

SECTION 12. Section 16050 of the Vehicle Code is amended as follows:

16050. *Establishing Proof of Financial Responsibility.*

(a) In order to establish proof of financial responsibility every driver or employer involved in an accident and required to report such accident by Section 16000 shall establish to the satisfaction of the department that the provisions of this article are applicable to his responsibilities arising out of the accident.

(b) A violation of this section is an infraction. A second or subsequent conviction of a violation of this section is a misdemeanor.

SECTION 13. Section 1852 of the Insurance Code is amended as follows:

1852. *Standards in making and using rates.*

The following standards shall apply to the making and use of rates pertaining to all classes of insurance to which the provisions of this chapter are applicable:

(a) *Excessive, inadequate, or unfairly discriminatory rates.* Rates shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory.

No rate shall be held to be excessive unless (1) such rate is unreasonably high for the insurance provided and (2) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

No rate shall be held to be inadequate unless (1) such rate is unreasonably low for the insurance provided and (2) the continued use of such rate endangers the solvency of the insurer using the same, or unless (3) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or if continued will have, the effect of destroying competition or creating a monopoly.

(b) *Loss experience.* Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to conflagration and catastrophe hazards; to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both ~~country/wide~~ *countrywide* and those specially applicable to this State, and to all other factors, including judgment factors, deemed relevant within and outside this State; and in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available.

Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(c) *Expense provisions.* The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(d) *Risk classification.* Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions.

(e) Enforcement. The commissioner shall have exclusive jurisdiction to enforce this section, subject to judicial review.

SECTION 14. Section 1850.01 is added to the Insurance Code as follows:

1850.01. Rates to be established by competition.

(a) No public official shall have or be granted the power to establish, fix, determine, set or require approval prior to effectiveness of any rate level for insurance (other than workers' compensation insurance or insurance issued pursuant to an assigned risk plan or other residual market mechanism).

SECTION 15. Section 10140 of the Insurance Code is reenacted as follows:

10140. *Practices based on race, color, etc. proscribed.*

No admitted insurer, licensed to issue life or disability insurance, shall fail or refuse to accept an application for such insurance, to issue such insurance to an applicant therefor, or issue or cancel such insurance, under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every race, color, religion, national origin, or ancestry; nor shall race, color, religion, national origin, or ancestry of itself constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for such insurance.

SECTION 16. Section 11628 of the Insurance Code is reenacted as follows:

11628. *Rosenthal-Robbins Auto Insurance Nondiscrimination Law.*

(a) No admitted insurer, licensed to issue and issuing motor vehicle liability policies as defined in Section 16450 of the Vehicle Code, shall fail or refuse to accept an application for such insurance, to issue such insurance to an applicant therefor, or issue or cancel such insurance under conditions less favorable to the insured than in other comparable cases, except for reasons applicable alike to persons of every race, language, color, religion, national origin, ancestry, or the same geographic area; nor shall race, language, color, religion, national origin, ancestry, or location within a geographic area of itself constitute a condition or risk for which a higher rate, premium, or charge may be required of the insured for such insurance.

As used in this section "geographic area" means a portion of this state of not more than 20 square miles defined by description in the rating manual of an insurer or in the rating manual of a rating bureau of which the insurer is a member or subscriber. In order that geographic areas used for rating purposes may reflect homogeneity of loss experience, a record of loss experience for such geographic area shall include the breakdown of actual loss experience statistics by zip code area (as designated by the United ~~State~~ *States* Postal Service) within each geographic area for family owned private passenger motor vehicles and light-weight commercial motor vehicles, under 1½-ton load capacity, used for local service or retail delivery, normally within a 50-mile radius of garaging, and which are not part of a fleet of five or more motor vehicles under one ownership. A record of loss experience for such geographic area, including such statistical data by zip code area, shall be submitted annually to the commissioner for examination by each insurer. An insurer may satisfy its obligation to report statistical data under this subparagraph by providing its loss experience data to a rating or advisory organization for submission to the commissioner. This data shall be made available to the public by the commissioner annually after examination; however, it shall be released in aggregate form by zip code in order that no individual insurer's loss experience for any specific geographic area be revealed. Differentiation in rates between geographical areas shall not constitute unfair discrimination.

All information reported to the department pursuant to this subdivision shall be confidential.

As used in this section, "language" means the inability to speak, read, write, or comprehend the English language.

(b) No admitted insurer, licensed to issue and issuing motor vehicle liability insurance policies as defined in Section 16450 of the Vehicle Code, shall fail or refuse to accept an application for such insurance, refuse to issue such insurance to an applicant therefor, or cancel such insurance solely for the reason that the applicant for such insurance or any insured is employed in a specific occupation.

Nothing in this section shall prohibit an insurer from:

(1) Considering the occupation of the applicant or insured as a condition or risk for which a higher rate or discounted rate may be required or offered for coverage in the course and scope of his or her occupation.

(2) Charging a deviated rate to any classification of risks involving a specific occupation, or grouping thereof, if the rate meets the requirements of Chapter 9 (commencing with Section 1850) of Part 2 of Division 1 and is based upon actuarial data which demonstrates a significant actual historical differential between losses or expenses attributable to the specific occupation, or grouping thereof, and the past losses or expenses attributable to other classification of risks. For purposes of compiling such actuarial data for a specific occupation or grouping thereof, a person shall be deemed employed in the occupation in which that data is compiled if: (A) the majority of his or her employment during the previous year was in the occupation, or (B) the majority of his or her aggregate earnings for the immediate preceding three-year period were derived from the occupation, or (C) the person is a member in good standing of a union which is an authorized collective bargaining agent for persons engaged in the occupation.

Nothing in this section shall be construed to include in the definition of "occupation" active duty service in the Armed Forces of the United States, any status or activity which does not result in remuneration for work done or services performed, or self-employment in a business operated out of an applicant's or insured's place of residence or persons engaged in the renting, leasing, selling, repossessing, rebuilding, wrecking or salvaging of motor vehicles.

(c) Nothing in this section shall limit or restrict the ability of an insurer to refuse to accept an application for or refuse to issue or cancel such insurance for the reason that it is a commercial vehicle or based upon the consideration of a vehicle's size, weight, design or intended use.

(d) It is the intent of the Legislature that actuarial data by occupation may be examined for credibility by the commissioner on the same basis as any other automobile insurance data which he or she is empowered to examine.

(e) The provisions of this section shall be known and may be cited as the "Rosenthal-Robbins Auto Insurance Nondiscrimination Law."

SECTION 17. Section 1853.10 of the Insurance Code is added as follows:

1853.10. Prohibition of anti-competitive behavior.

(a) Consistent with the provisions of the Insurance Code, generally, and of this Chapter 9, specifically:

(1) No insurer shall monopolize or attempt to monopolize, or combine or conspire with any other insurer or with a rating or advisory organization to monopolize, in any territory, any class of insurance as defined in Sections 100 through 121 of Chapter 1 of Part 1 of Division 1 of the Insurance Code.

(2) No insurer shall agree with any other insurer or with a rating or advisory organization to adhere to any rate.

(3) No insurer shall make any agreement with any other insurer or rating or advisory organization to refuse to provide any class of insurance as defined in Sections 100 through 121 of Chapter 1 of Part 1 of Division 1 of the Insurance Code.

(4) No insurer or rating or advisory organization shall enter into an agreement to commit any act of boycott, coercion or intimidation.

(5) No insurer shall enter into an agreement with any other insurer or rating or advisory organization to withhold any class of insurance as defined in Sections 100 through 121 of Chapter 1 of Part 1 of Division 1 of the Insurance Code.

(6) No rating or advisory organization shall preclude any insurer from making its rates independently of such rating organization or charging rates different from the rates made by the rating organization.

(b) (1) Any rate made or action taken in violation of subdivision (a) may be disapproved by the commissioner pursuant to the applicable procedures prescribed in Section 1857.2. Nothing in this section shall be construed to apply to or prohibit any rate made or such other actions as may be authorized or permitted under this Code in general or this Chapter 9 in particular. Without limiting the generality of the preceding sentence, the prohibitions of Section 1853.10 shall not be construed to apply to or prohibit joint activity by or among: (i) two or more insurers having a common ownership or control or operating in this State under common ownership or control; (ii) joint underwriting, joint reinsurance, or pooling arrangements authorized or permitted by the Insurance Code or the commissioner including, but not limited to, those established to provide property insurance; automobile insurance on an assigned risk basis; child care liability insurance or such similar arrangements as may now or hereafter be established; (iii) joint underwriting, joint reinsurance, or pooling arrangements pertaining to the availability of insurance or the ability of an insured or insureds to obtain desired coverages, amounts of insurance or limits of liability; (iv) insurers with respect to the apportionment of casualty insurance as authorized by Section 1853.8 of this Chapter; or (v) insurers and rating or advisory organizations exchanging, analyzing, or otherwise developing, information and experience data as provided in this Chapter 9 of the Insurance Code.

(2) As the exclusive methods for enforcing this Section, the Commissioner may initiate action under Section 1857.2 or a person injured in his business or property by reason of anything forbidden in subdivision (a) of this Section may file a complaint and request a hearing with the Commissioner in accordance with the procedures prescribed in Section 1858.

SECTION 18. Section 12901.6 of the Insurance Code is added as follows:

12901.6. Prohibition of conflicts of interest.

Neither the commissioner nor any deputy or employee of the department shall, within one year after his or her tenure in office or termination of employment, represent, or counsel, advise or assist in representing, any insurer or licensee before the department in connection with any particular matter involving specific parties (i) that was actually pending under his or her official responsibility within a period of one year prior to the termination of such responsibility or (ii) in which he or she participated personally or substantially as an officer or employee.

SECTION 19. Section 12921.6 of the Insurance Code is added as follows:

12921.6. Administrative interpretations.

For the guidance of insurers and others obligated to comply with this code and other laws regulating the business of insurance in this State, the commissioner may issue written administrative interpretations of any provision of this code or any other law regulating the business of insurance in this State. No person shall be liable for any action taken in good faith conformity with and in reliance on any such administrative interpretation. An insurer whose policy has been written and premium determined in good faith conformity with and in reliance on any administrative interpretation shall not be liable to provide different coverage during the term of such policy even if the administrative interpretation relied upon shall be determined to be incorrect. Any person aggrieved by any such administrative interpretation may obtain judicial review thereof in such manner as may be provided by law.

SECTION 20. Section 1643 of the Insurance Code is amended as follows:

1643. *Bank, holding company, subsidiary, affiliate and officers and employees; prohibition against licensing; exception.*

(a) No bank, or bank holding company, subsidiary, or affiliate thereof, or any officer or employee of a bank, bank holding company, subsidiary, or affiliate, may be licensed as an insurance agent or broker or act as an agent or broker for insurance, in this state, or control a licensed insurance agent or broker, except that a bank or a bank holding company subsidiary, or affiliate of a bank, may be issued a license to act as a life and disability agent limited to the transaction of credit life and disability insurance, or an agent limited to the transaction of insurance which is limited solely to assuring repayment of the outstanding balance due on a specific extension of credit by a bank or bank holding company or its subsidiary in the event of the involuntary unemployment of the debtor, or both. A commercial bank may be licensed to sell insurance or act as an insurance broker as provided in Section 1208 of the Financial Code. This section shall not apply to any bank or bank holding company which, under the authorization of the Federal Reserve Board, had prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance (except that subsequent authorization to expand such activities shall be subject to this section), or to any bank holding company owning a state-chartered bank which had, prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance. This section shall not apply to any person authorized or licensed to make loans pursuant to Division 7 (commencing with Section 18000), Division 9 (commencing with Section 22000), Division 10 (commencing with Section 24000), or Division 11 (commencing with Section 26000) of the Financial Code.

(b) For the purposes of this section, the following definitions shall apply:

~~(a)~~ *(1)* "Bank" means any institution in this state defined in Section 102 of the Financial Code except that such term does not include a title insurance company authorized to transact a trust business under the provisions of Article 4 (commencing with Section 12390) of Chapter 1 of Part 6 of Division 2 or a trust company controlled by or under common control with a title insurance company.

~~(b)~~ *(2)* "Bank holding company" means the same as the definition of that term set forth in Section 2 of the federal Bank Holding Company Act of 1956, as amended, but limited to holding companies which control a bank authorized to accept deposits in this state.

~~(c)~~ *(3)* "Subsidiary" means any corporation, association, or partnership, owned in whole or part by a bank or bank holding company.

~~(d)~~ *(4)* "Affiliate" means any corporation, association, or partnership connected through the ownership of a 10-percent or greater interest by a common parent.

~~(e)~~ *(5)* "Credit life, health, and accident insurance" means insurance on the life and health of a borrower from a bank issued to secure the repayment of the amount borrowed.

~~(f)~~ *(6)* "Control" means the possession, by any means, of the power to direct or cause the direction of the management or activities of a licensed insurance agent or broker.

(c) The provisions of this section may be amended by the Legislature by Statute.

SECTION 21. Section 750 of the Insurance Code is reenacted as follows:

750. *Rebate of premium.*

An insurer, insurance agent, broker, or solicitor, personally or by any other party, shall not offer or pay, directly or indirectly, as an inducement to insurance on any subject-matter in this State, any rebate of the whole or part of the premium payable on an insurance contract, or of the agent's or broker's commission thereon, and such rebate is an unlawful rebate.

SECTION 22. Section 750.1 of the Insurance Code is amended as follows:

750.1. *Unlawful rebates, profits and commissions; legislative findings, declarations and intent.*

The ~~Legislature~~ *people* hereby ~~finds~~ *find* and ~~declares~~ *declare* that the continued regulation of the business practices of insurers and their producers is in the interest of the citizens of the state and that the control and limitations of unlawful rebates, profits, and commissions is an essential component of that regulation which is necessary to effectuate an adequate and complete system and regulation of insurer and producer business practices.

The ~~Legislature~~ *people* ~~finds~~ *find* that the statutes controlling unlawful rebates, profits, and commissions continue to provide critical protection to insureds in this state from the numerous consequences that would occur in the absence of such regulation, including company insolvencies, unfair discrimination between insureds with identical risks creating subsidies from small purchasers of insurance in favor of large purchasers of insurance, decreased quality of services to insurance consumers, increased concentration of insurance distribution and sales mechanisms, and misrepresentation and unethical sales practices such as improper replacement or twisting to the detriment of the public.

It is the intent of the ~~Legislature~~ *people* in ~~enacting~~ *reenacting* this section to clearly set forth the ~~legislative~~ intent supporting the enactment, continuing vitality, and importance of the unlawful rebates, profits, and commissions sections of this code.

SECTION 23. Section 751 of the Insurance Code is reenacted as follows:

751. *Specification of consideration in policy or application.*

An insurer, or an insurance agent, broker, or solicitor, personally or otherwise, shall not offer or pay, directly or indirectly, as an inducement to enter into an insurance contract, any valuable consideration which is not clearly specified, promised or provided for in the policy, or application for the insurance, and any such consideration not appearing in the policy is an unlawful rebate.

SECTION 24. Section 752 of the Insurance Code is reenacted as follows:

752. *Acceptance of rebate; misdemeanor.*

Any person named as the insured in any policy or named as the principal, or obligee, in any surety policy or the agent or representative of any such person who, directly or indirectly, knowingly accepts or receives any unlawful rebate is guilty of a misdemeanor.

SECTION 25. Section 754 of the Insurance Code is reenacted as follows:

754. *Payments to insurance brokers.*

Payments of commissions or fees by insurers or their agents to insurance brokers, when otherwise lawful under this code, are expressly authorized.

SECTION 26. Section 755 of the Insurance Code is reenacted as follows:

755. *Splitting commissions.*

The paying or allowing of any commission or other valuable consideration on insurance business in this State to other than an admitted insurer or a licensed insurance agent, broker or solicitor is an unlawful rebate.

SECTION 27. Section 755.2 of the Insurance Code is reenacted as follows:

755.2. *Receipt of continuing commissions on policy.*

If at the time of the solicitation and issuance of a policy of life or disability insurance, or of a surety bond which by its terms continues until canceled, a person may lawfully receive commissions thereon, such person, or in the event of his death, his estate or heirs may continue to receive commissions thereon during the continuance in force or renewal of such policy or bond without being licensed under the provisions of Chapter 5, Part 2, Division 1 of this code, provided:

(a) Such recipient does not transact insurance in connection with such policy or bond while not so licensed; and

(b) The payment is made pursuant to a contract entered into, before such solicitation and issuance, between the insurer paying or allowing the commission and such person.

SECTION 28. Section 755.5 of the Insurance Code is reenacted as follows:

755.5. *Receipt of commissions by agents, solicitors, and insurers.*

It is unlawful for an insurance agent who is not also licensed as an insurance broker to receive commissions derived from insurance placed with an insurer which has not appointed him to act as its agent in the transaction of such insurance.

It is unlawful for an insurance solicitor to receive commissions on insurance from any source other than the employer for whom he is licensed excepting on life or disability insurance transacted by him under individual licenses as life or disability agent issued to him pursuant to this code.

It is unlawful for any person to pay to an insurance agent or solicitor any commissions which he can not lawfully receive.

Except as provided in Section 763 it is unlawful for an insurer to receive for its own use commissions on insurance placed with another insurer.

SECTION 29. Section 755.6 of the Insurance Code is reenacted as follows:

755.6. *Insurer participating in assigned risk plan; payment of commission for additional coverages.*

Notwithstanding the provisions of Section 755.5, an insurer participating in any Assigned Risk Plan, as provided for in Article 4 (commencing with Section 11620), Chapter 1, Part 3, Division 2 of the Insurance Code, may pay to a licensed insurance agent, and such agent may receive, a commission or consideration on any automobile or liability coverages written in addition to any commission or consideration required under such plan if such agent has been designated by the applicant for insurance as producer of record for the coverages required under such plan.

SECTION 30. Section 755.7 of the Insurance Code is reenacted as follows:

755.7. *Advising persons concerning insurance for consideration; allowing credit for service; misdemeanor.*

Any person, including but not limited to any person licensed, certificated under this code or exempted under this code from regulation, who for consideration advises, or agrees to advise, any person concerning insurance, insurance policies, insurance needs or insurance programs of any sort and who agrees to, or does, allow credit against such consideration for such service for any portion of any insurance commission which may accrue, directly or indirectly, to such person who so advises or agrees to advise, is guilty of making an unlawful rebate and guilty of a misdemeanor.

SECTION 31. Section 756 of the Insurance Code is reenacted as follows:

756. *Misrepresentation of pay roll to procure lower premium.*

When the premium on a policy insuring an employer is based upon the amount or segregation of the employer's pay roll, and the employer, personally or knowingly through his employee, procures a lower premium by ~~wilfully~~ *willfully* misrepresenting the amount or segregation, such misrepresentation is an unlawful rebate as to the employer.

Liability to state; penalty. In addition to any penalty provided by law for unlawful rebates, the employer in such case is liable to the State in an amount ten times the difference between the lower premium paid and the premium properly payable. The commissioner shall collect the amount so payable and may bring a civil action in his name as commissioner to enforce collection unless the misrepresentation is made to and lower premium procured from the State Compensation Insurance Fund. In the latter case the liability to the State under this section shall be enforced in a civil action in the name of the State Compensation Insurance Fund and any amount so collected shall become a part of that fund.

SECTION 32. Section 757 of the Insurance Code is reenacted as follows:

757. *Insurer's acceptance of false pay roll statement.*

When a statement of the amount or segregation of a pay roll is materially false, and an insurer, through a person employed by it in a managerial capacity, accepts the statement as the basis for the premium on a policy, the acceptance is an unlawful rebate if the accepting employee knows of the falsity.

SECTION 33. Section 758 of the Insurance Code is reenacted as follows:

758. *Insurer's duty of diligence.*

Every insurer shall exercise reasonable diligence in securing the observance of this article by its agents.

SECTION 34. Section 759 of the Insurance Code is reenacted as follows:

759. *Appointment of agent for rebate.*

It is unlawful for any insurer to appoint an agent for the purpose of enabling such agent, or the employer or person requesting the appointment of the agent, to obtain insurance at a cost less than that specified in the policy, or at a cost less than that specified in the application therefor.

SECTION 35. Section 760 of the Insurance Code is reenacted as follows:

760. *Personal or controlled insurance.*

Definitions. As used in this section "personal or controlled insurance" means insurance covering an insurance agent, broker, or solicitor, or

(a) His spouse, his employer or his employer's spouse.

(b) Any person related to him or the persons mentioned in subdivision (a) within the second degree by blood or marriage.

(c) If his employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent or broker is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent or broker and any corporation which is also similarly directly or indirectly controlled by the person who directly or indirectly controls the agent or broker.

(f) If the agent or broker is a corporation, any corporation making consolidated returns for United States income tax purposes with any corporation described in subdivision (e).

Unlawful rebate. If premiums on personal or controlled insurance transacted by an insurance agent, broker, or solicitor payable in one year exceed the premiums on other insurance transacted by such licensee payable in the same year, the receipt of commissions upon the excess is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such agent, broker, or solicitor, in any manner as an agent, broker or solicitor, whether continuously licensed or not, if premiums on personal or controlled insurance transacted by him payable in any one such calendar year exceed 33⅓ percent of the other premiums transacted by him payable in the same calendar year, the receipt of commissions upon the excess over such 33⅓ percent is an unlawful rebate. For the ~~purposes~~ *purpose* of this paragraph, if the agent or broker be an organization the sixth calendar year shall be the first calendar year beginning five years or more after the initial licensing of the organization, or any predecessor thereof, as an agent or broker.

Inapplicability to certain individual licensees. Provided further, that this section does not apply to an individual licensee who: (1) is licensed during all of such calendar year as a solicitor, or individually as an agent or broker; (2) during such calendar year conducts an individual business, not being named to transact on any organization license nor owning any interest in any corporation or partnership transacting an insurance agency or brokerage business; (3) has been continuously licensed in some manner as an active agent, broker or solicitor for at least 25 years; and (4) is at least 65 years of age at the beginning of the calendar year.

Presumptions. Whenever an officer or director of a corporation acts as agent, broker, or solicitor in the transaction of insurance covering the corporation, he shall be conclusively presumed to have received the full commission on such contract while an employee of the corporation. Whenever the remuneration for services of an employee is decreased by the employer or is made unreasonably small in amount but the employee is permitted, as an insurance agent, broker, or solicitor, to transact personal or controlled insurance, it shall be conclusively presumed that such employee receives the full amount of commission on such personal or controlled insurance.

Year defined; suspension, revocation or denial of license. "Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

SECTION 36. Section 760.5 of the Insurance Code is reenacted as follows:

760.5. *Personal or controlled life insurance.*

Definition. As used in this section "personal or controlled insurance" means insurance covering a life agent, or

(a) His spouse, his employer, his employer's spouse, or any group of employees under a group policy issued to his employer.

(b) Any person related to him, his spouse, his employer or his employer's spouse within the second degree by blood or marriage.

(c) If his employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent.

Unlawful rebate. If commissions on personal or controlled insurance transacted by a life agent under his license as a life agent received in one year exceed the commissions received in that year on other insurance transacted by such licensee under his license as life agent, the receipt of commissions upon personal or controlled insurance in excess of those on such other insurance is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such life agent in any manner as a life agent, disability agent or life disability agent, whether continuously licensed or not, if commissions on personal or controlled insurance transacted by him under any or all such licenses received in any such calendar year exceed 33⅓ percent of the commissions received in the same calendar year on other insurance transacted by him under any or all such licenses, the receipt of commissions upon personal or controlled insurance in excess of 33⅓ percent of those on such other insurance is an unlawful rebate. For the purposes of this paragraph, if the license be a joint firm license: The sixth calendar year as respects the firm shall be the first calendar year beginning five years or more after the initial licensing of the firm or any predecessor thereof as a joint firm licensee with any individual; the firm may be charged with a violation of this section separately based upon all joint firm licenses it may have held during the calendar year; and an individual named on one or more joint firm licenses may be charged with a violation of this section separately based upon all life licenses, individual and joint firm, he may have held during the calendar year.

Inapplicability to certain individual licensees. Provided, further, that this section does not apply to an individual licensee who: (1) is licensed during all of such calendar year under one or more kinds of individual life licenses; (2) during all of such calendar year conducts an individual business, not being named in any joint firm license nor owning any interest in a corporation or partnership transacting business under any kind of life license; (3) has been continuously licensed in some manner as an active agent under some kind of life license for at least 25 years; and (4) is at least 65 years of age at the beginning of the calendar year.

Year defined; suspension, revocation or denial of license. "Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

SECTION 37. Section 761 of the Insurance Code is reenacted as follows:

761. *Making or receiving unlawful rebate; misdemeanor.*

Any insurer, insurance agent, broker, solicitor, or life agent and any officer or employee of an insurer, insurance agent, broker, or life agent that makes or receives an unlawful rebate is guilty of a misdemeanor.

SECTION 38. Section 763 of the Insurance Code is reenacted as follows:

763. *Acts not unlawful rebates.*

The following acts are not unlawful rebates:

(a) *Dividends on participating policies.* The return by an insurer issuing policies on a participating plan, or any portion of the premium as a dividend after the expiration of the term covered by such policy.

(b) *Commissions.* The payment of commission by any insurer, or its agent, broker or solicitor, to another insurer, or insurance agent, broker or solicitor, upon insurance lawfully transacted in that capacity.

(c) *Marine discounts.* The allowance by any marine insurer, or marine insurance agent, broker, or solicitor to any insured, of such usual discount as is sanctioned by custom among marine insurers as being additional to the agent's or broker's commission.

(d) *Commissions to insured payee.* The paying by an insurer to another insurer, or to an insurance agent, broker, or solicitor, of a commission in respect to a policy under which the payee is insured, or the receiving by such payee of such commission.

(e) *Bonuses on nonparticipating life policies.* The paying by an insurer of ~~s~~ to policyholders on nonparticipating life insurance or otherwise abating ~~p~~remiums, in whole or in part, out of surplus accumulated from nonparticipating insurance.

(f) *Dividends on participating life policies.* The return as a dividend by a life insurer of any portion of the premium on policies issued on a participating plan at any time.

(g) *Adjustments for direct payment of industrial life premiums.* The return, by an insurer transacting industrial insurance on a weekly payment plan, to policyholders who have made premium payments for a period of at least one year directly to the insurer at its home or district office, of a percentage of the premium which the insurer would have paid for the weekly collection of such premiums.

(h) *Existing life policies.* The paying by any life insurer, or the receiving by life insurance policyholders of special compensations, or the allowing and receiving of credits already agreed upon in life insurance contracts now in force.

(i) *Insurer's group life plan for own employees.* The payment by an insurer of any portion of life insurance premiums payable by its employees pursuant to a life insurance program under which 75 ~~per cent~~ *percent* or more of its employees are required to carry life insurance on their lives so long as they remain in the employment of insurer.

(j) *Cosureties.* The payment or allowance of a fee or commission by one surety insurer to another surety insurer in respect to a risk on which both are cosureties.

SECTION 39. Section 763.5 of the Insurance Code is reenacted as follows:

763.5. *Sale of agent's or broker's business.*

The sale of the good will, business, list of policyholders or similar assets of an agent or broker in consideration of commissions or portions thereof to be thereafter earned by the use of such assets and payments of such consideration are not unlawful rebates if the purchaser is duly licensed to transact insurance and the receipt of the commissions would not constitute a violation of Section 760 if the person receiving them were licensed as an insurance agent.

SECTION 40. Section 764 of the Insurance Code is reenacted as follows:

764. *Privilege against self-incrimination.*

Any person may be compelled to testify or produce evidence at the trial or hearing on a charge of violating a provision of this article, even though such testimony or evidence may incriminate him. A prosecution shall not be brought or maintained against such person for any act concerning which he thus testifies or produces evidence, except for perjury committed in so testifying.

SECTION 41. Section 765 of the Insurance Code is reenacted as follows:

Suspension of certificate of authority.

~~i~~ insurer knowingly violates any provisions of this article, or knowingly permits any officer, agent, or employee so to do, the commissioner, after a hearing in accordance with the procedure provided in Section 704, may suspend the insurer's certificate of authority to do the class of insurance in which the violation of this article occurred.

SECTION 42. Section 766 of the Insurance Code is reenacted as follows:

766. *Suspension or revocation of license.*

If an insurance agent, broker, or solicitor knowingly and wilfully violates any of the provisions of this article, the commissioner, after a hearing in accordance with the procedure provided in Article 13 of Chapter 5 of this part may suspend or revoke the violator's license.

SECTION 43. Section 767 of the Insurance Code is reenacted as follows:

767. *Payment of commission to agent or broker licensed in Mexico.*

Notwithstanding any provision in this article to the contrary, it shall not be unlawful for any licensed insurance broker to pay a commission to an agent or broker licensed under the laws of Mexico when such agent or broker in Mexico refers to the insurance broker licensed in this state a resident of Mexico who wishes to obtain a policy of automobile liability insurance to be effective in this state from an insurer licensed in this state, and such broker negotiates and effects such a policy of insurance for such resident of Mexico.

SECTION 44. Section 1850 of the Insurance Code is reenacted as follows:

1850. *Purpose of chapter.*

The purpose of this chapter is to promote the public welfare by regulating insurance rates as herein provided to the end that they shall not be excessive, inadequate or unfairly discriminatory, to authorize the existence and operation of qualified rating organizations and advisory organizations and require that specified rating services of such rating organizations be generally available to all admitted insurers, and to authorize cooperation between insurers in rate making and other related matters.

It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis and nothing in this chapter is intended to give the Commissioner power to fix and determine a rate level by classification or otherwise.

SECTION 45. Section 1850.1 of the Insurance Code is reenacted as follows:

1850.1. *Rating organization defined.*

In this chapter "rating organization" means every person, other than an ~~a~~mitted insurer, whether located within or outside this State, who has as his ~~p~~r purpose the making of rates, rating plans or rating systems. Two or more ~~i~~l insurers which act in concert for the purpose of making rates, rating ~~p~~ or rating systems, and which do not operate within the specific authorizations contained in Sections 1853.5, 1853.7, 1853.8, and Article 5 shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

SECTION 46. Section 1850.2 of the Insurance Code is reenacted as follows:

1850.2. *Advisory organization defined.*

In this chapter "advisory organization" means every person, other than an admitted insurer, whether located within or outside this State, who prepares policy forms or makes underwriting rules incident to but not including the making of rates, rating plans or rating systems, or which collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate making, capacity. No duly authorized attorney at law acting in the usual course of his profession shall be deemed to be an advisory organization.

SECTION 47. Section 1850.3 of the Insurance Code is reenacted as follows:

1850.3. *Member and subscriber defined.*

Unless otherwise apparent from the context, in this chapter:

(a) "Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory or other organization.

(b) "Subscriber" means an insurer which is furnished at its request (1) with rates and rating manuals by a rating organization of which it is not a member, or (2) with advisory services by an advisory organization of which is is not a member.

SECTION 48. Section 1853 of the Insurance Code is reenacted as follows:

1853. *Concerted action of insurers.*

Subject to and in compliance with the provisions of this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research.

SECTION 49. Section 1853.5 of the Insurance Code is reenacted as follows:

1853.5. *Insurers having common ownership or management; concerted action.*

With respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research, two or more admitted insurers having a common ownership or operating in this State under common management or control, are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer, and to the extent that such matters relate to co-surety bonds, two or more admitted insurers executing such bonds are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer.

SECTION 50. Section 1853.6 of the Insurance Code is reenacted as follows:

1853.6. *Agreements to adhere to rates.*

Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules or policy or bond forms of such organizations, either consistently or intermittently, but, except as provided in Sections 1853.5, 1853.8, and Article 5, shall not agree with each other or rating organizations or others to adhere thereto. The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization, or the underwriting rules or policy or bond forms prepared by a rating or advisory organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any such agreement.

SECTION 51. Section 1853.7 of the Insurance Code is reenacted as follows:

1853.7. *Exchange of information and experience data.*

Licensed rating organizations and admitted insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to rate-making and the application of rating systems.

SECTION 52. Section 1854 of the Insurance Code is reenacted as follows:

1854. *Requirement of license; application; fee.*

No rating organization shall conduct its operations in this state without first filing with the commissioner a written application for and securing a license to act as a rating organization. Any rating organization may make application for and obtain a license as a rating organization if it shall meet the requirements for license set forth in this chapter. Every such rating organization shall file with its application (a) a copy of its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business, all duly certified by the custodian of the originals thereof, (b) a list of its members and subscribers, (c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served, and (d) a statement of its qualifications as a rating organization.

The fee for filing an application for license as a rating organization is one hundred seventy-seven dollars ($177) lawful money of the United States, payable in advance to the commissioner.

SECTION 53. Section 1854.1 of the Insurance Code is reenacted as follows:

1854.1. *Requisites for obtaining and retaining license.*

To obtain and retain a license, a rating organization shall provide satisfactory evidence to the commissioner that it will:

(a) Permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination, or withdraw therefrom.

(b) Neither have nor adopt any rule or exact any agreement, the effect of which would be to require any member or subscriber as a condition to membership or subscribership, to adhere to its rates, rating plans, rating systems, underwriting rules, or policy or bond forms.

(c) Neither adopt any rule nor exact any agreement the effect of which would

be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their ~~policy holders~~ *policyholders*, members or subscribers.

(d) Neither practice nor sanction any plan or act of boycott, coercion or intimidation.

(e) Neither enter into nor sanction any contract or act by which any person is restrained from lawfully engaging in the insurance business.

(f) Notify the commissioner promptly of every change in its constitution, its articles of incorporation, agreement or association, and of its by-laws, rules and regulations governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this State designated by it upon whom notices or orders of the commissioner or process affecting such organization may be served.

(g) Comply with the provisions of Section 1857.

SECTION 54. Section 1854.2 of the Insurance Code is reenacted as follows:

1854.2. *Investigation of applicant; requirements for issuance of license; limited license; license period.*

The commissioner shall examine each application for license to act as a rating organization and the documents filed therewith and may make such further investigation of the applicant, its affairs and its proposed plan of business, as he deems desirable.

The commissioner shall issue the license applied for within 60 days of its filing with him if from such examination and investigation he is satisfied that:

(a) The business reputation of the applicant and its officers is good.

(b) The facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish.

(c) The applicant and its proposed plan of operation conform to the requirements of this chapter.

Otherwise, but only after hearing upon notice, the commissioner shall in writing deny the application and notify the applicant of his decision and his reasons therefor.

The commissioner may grant an application in part only and issue a license to act as a rating organization for one or more of the classes of insurance or subdivisions thereof or class of risk or a part or combination thereof as are specified in the application if the applicant qualifies for only a portion of the classes applied for.

Licenses issued pursuant to this section shall remain in effect until revoked as provided in this chapter.

SECTION 55. Section 1854.25 of the Insurance Code is reenacted as follows:

1854.25. *Annual fee.*

Notwithstanding the provision of Section 1854.2, each rating organization possessing a license of indefinite term pursuant to such section shall owe and pay to the commissioner an annual fee of one hundred seventy-seven dollars ($177) in lawful money of the United States in advance on account of such license until its final termination. Such fee shall be for periods commencing ~~on~~ July 1, 1964, and on each July 1st thereafter and ending on June 30, 1965, and each June 30th thereafter, and shall be due and payable on March 1, 1964, and on each March 1st thereafter and shall be delinquent on April 1, 1964, and each April 1st thereafter.

SECTION 56. Section 1854.3 of the Insurance Code is reenacted as follows:

1854.3. *Membership eligibility rules.*

Subject to the approval of the commissioner licensed rating organizations may make reasonable rules governing eligibility for membership.

SECTION 57. Section 1854.4 of the Insurance Code is reenacted as follows:

1854.4. *Insurers with common ownership or management; conditions of membership.*

If two or more insurers having a common ownership or operating in this State under common management are admitted for the classes or types of insurance for which a rating organization is licensed to make rates, the rating organization may require as a condition to membership or subscribership of one or more that all such insurers shall become members or subscribers.

SECTION 58. Section 1854.5 of the Insurance Code is reenacted as follows:

1854.5. *Workers' compensation insurance rating organizations; exemption from licensing or registration requirements of this chapter; authority.*

A workers' compensation insurance rating organization licensed pursuant to the provisions of Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 which does not make rates, rating plans or rating systems for insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 901, et seq.) shall not be required to be licensed as a rating organization or registered as an advisory organization pursuant to the provisions of this chapter and shall have authority under its license as a workers' compensation insurance rating organization to:

(a) Collect and tabulate loss and expense experience statistics and other information and data relating to insurance covering employers against their liability for compensation under the United States Longshoremen's and Harbor Workers' Compensation Act.

(b) Furnish or exchange such information and experience data to or with rating organizations, advisory organizations and insurers in this and other states.

(c) Adopt and enforce compliance by its insurer members with reasonable rules and statistical plans to be used in the recording and reporting by insurer members of their California longshoremen's and harbor workers' insurance loss and expense experience in order that such experience of all ~~of~~ its insurer members shall be available in such form and detail as will be of aid to the commissioner in the enforcement of, and to its insurer members in complying with, the provisions of this chapter.

(d) Engage in the same activities and carry out the same functions with respect to insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act that it is authorized to engage in or carry out with respect to California workers' compensation insurance generally under the provisions of Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 other than the making of rates, rating plans and rating systems.

SECTION 59. Section 1857.5 of the Insurance Code is reenacted as follows:

1857.5. *Rules and statistical plans; promulgation; compilations.*

(a) The commissioner may promulgate reasonable rules and statistical plans reasonably adapted to each of the rating systems in use within the state, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in this chapter. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience. In promulgating such rules and plans, the commissioner may give due consideration to the rating systems in use and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system in use by it. The commissioner may designate one or more rating organizations or advisory organizations to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(b) Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

(c) In order to further uniform administration or rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

SECTION 60. Section 1857.7 of the Insurance Code is reenacted as follows:

1857.7. *Products liability insurers; transmission of information.*

(a) Any insurer issuing a policy of products liability insurance in this state shall transmit the following information, based on its nationwide products liability insurance writings, to the department each year in the annual report of the insurer:

(1) Premiums written.

(2) Premiums earned.

(3) Unearned premiums.

(4) The dollar amount of claims paid.

(5) The number of outstanding claims.

(6) Net loss reserves for outstanding claims excluding claims incurred but not reported.

(7) Net loss reserves for claims incurred but not reported.

(8) Losses incurred as a percentage of premiums earned.

(9) Net investment gain or loss and other income or gain or loss allocated to products liability lines.

(10) Net income before federal and foreign income taxes.

(11) Expenses incurred including loss adjustment expense, commission and brokerage expense, other acquisition expense and general expense.

(b) The reports provided pursuant to subdivision (a) shall be available for public inspection and shall be retained on file by the department for five years.

(c) The reports required by subdivision (a) shall only contain information for the year for which the reports are being filed.

(d) Any information provided by any insurer to the department pertaining to a specific claim or a products liability insurance policy shall be classified as confidential and shall not be revealed by the department.

SECTION 61. Section 1857.9 of the Insurance Code is reenacted as follows:

1857.9. *Report; contents; designating classes of insurance generally unavailable, unaffordable, or for which there have been unusually great premium increases; information on classes of insurance; excluded commercial liability insurance; filing reports; emergency regulations.*

(a) Every insurer doing business in this state, except as provided by subdivision (g), shall report on a calendar year basis for each class of insurance designated in the prior calendar year by the commissioner pursuant to subdivision (b) and for each class listed in subdivision (c), both for policies issued or issued for delivery in California, and for policies issued or issued for delivery in the United States and territories:

(1) The number of policies written, the direct premiums written, the direct premiums earned, the direct losses paid, the direct losses incurred, the direct losses unpaid (not including losses incurred but not reported) the number of outstanding claims at year end and the number of claims paid in the preceding year, the allocated loss adjustment expense, and the percentage of allocated loss adjustment expense attributable to defense attorney expenses.

(2) Whether policies are written on a claim made or occurrence basis, and whether there has been a change in the preceding 12 months.

(3) For each loss reserve for each class, whether the reserve is discounted in anticipation of future investment earnings.

(4) The commissioner shall waive the requirements of paragraph (1) for any information that has been provided to the Insurance Services Office by any insurer, if the Insurance Services Office provides the information to the commissioner on or before the date on which the insurer is required to file the statement.

(b) No later than October 1 of each year the commissioner shall designate those classes of insurance, as defined by the Insurance Service Office, that are generally unavailable or unaffordable in California, or for which there have been unusually

great premium increases. The factors the commissioner shall consider in making this determination shall include, but are not limited to, the following:

(1) Consumer complaints.

(2) Rate complaints.

Surveillance by the department.

larket conduct.

In addition to the classes designated by the commissioner pursuant to subdivision (b) the insurer shall include the information required by subdivision (a) for those classes of insurance, as defined by the Insurance Services Office, covering liability insurance for municipalities, products liability insurance, liability insurance for any business or nonprofit enterprise required to carry liability insurance by state law, news publishers' liability insurance, and professional errors and omissions (malpractice) liability insurance for doctors and for lawyers. Collection of the data described in this section shall be terminated upon a joint resolution of the Legislature specifying such termination of collection. Insurers shall not be required to report under this section information required to be reported under Sections 1857.7, 1864, 11555.2, and 12958.

(d) The insurer shall also report for both California and for the United States and its territories for the calendar year:

(1) Each class of commercial liability insurance, as defined by the Insurance Services Office, that is specifically excluded from any reinsurance treaty for reinsurance ceded.

(2) Each class of commercial liability insurance, as defined by the Insurance Services Office, that is specifically excluded from any reinsurance treaty for reinsurance assumed.

(e) The department shall retain the information reported pursuant to this section for a period of no less than five years.

(f) Insurers that are members of the same insurance group may aggregate the information required by this section in a single report.

(g) The reports required by this section shall not be applicable to any insurer that has been established for less than three years.

(h) The reports required by this section shall be filed on a form provided by the commissioner no later than May 1 of the calendar year following the year for which the information is reported.

(i) The department shall adopt regulations implementing this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Division 3 of Title 2 of the Government Code, except that for the purposes of Chapter 3.5 (commencing with Section 11340) of Division 3 of Title 2 of the Government Code, any regulations adopted under this section shall be deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall remain in effect for

The regulations may require insurers to report the information required by ision (d) by categories other than those used by the Insurance Services Of

(j) The information provided pursuant to subdivision (a) shall be confidential and not revealed by the department, except that the commissioner may publish an analysis of the data in aggregate form or in a manner which does not disclose confidential information about identified insurers or insureds.,

SECTION 62. Sections 1860.1 and 1860.2 of the Insurance Code are reenacted as follows:

1860.1. *Applicability of other laws.*

No act done, action taken or agreement made pursuant to the authority conferred by this chapter shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this State heretofore or hereafter enacted which does not specifically refer to insurance.

1860.2. *Applicability of other laws.*

The administration and enforcement of this chapter shall be governed solely by the provisions of this chapter. Except as provided in this chapter, no other law relating to insurance and no other provisions in this code heretofore or hereafter enacted shall apply to or be construed as supplementing or modifying the provisions of this chapter unless such other law or other provisions expressly so provides and specifically refers to the sections of this chapter which it intends to supplement or modify.

SECTION 63. Section 11628.3 of the Insurance Code is reenacted as follows:

11628.3. *Operators over 55; driver improvement course graduates; reduction in premium.*

(a) Based on the actuarial and loss experience data available to each insurer, including the driving records of mature driver improvement course graduates, as recorded by the Department of Motor Vehicles, every admitted insurer shall provide for an appropriate percentage of reduction in premium rates for motor vehicle liability insurance for principal operators who are 55 years of age or older and who produce proof of successful completion of the mature driver improvement course provided for and approved by the Department of Motor Vehicles pursuant to Section 1675 of the Vehicle Code.

(b) The insured shall enroll in and successfully complete the course described in subdivision (a) once every three years in order to continue to be eligible for an appropriate percentage of reduced premium.

(c) The percentage of premium reduction required by subdivision (a) shall be reassessed by the insurer upon renewal of the insured's policy. The insured's eligibility for any percentage of premium reduction shall be effective for a three-year period from the date of successful completion of the course described in subdivision (a), except that the insurer may discontinue the reduced premium rate if the insured is in any case:

(1) Involved in an accident for which the insured is at fault, as determined by the insurer.

(2) Convicted of a violation of Division 11 (commencing with Section 21000) of the Vehicle Code, except Chapter 9 (commencing with Section 22500) of that division, or of a traffic related offense involving alcohol or narcotics.

(d) The percentage of premium rate reduction required by subdivision (a) does not apply in the event the insured enrolls in, and successfully completes, an approved course pursuant to a court order provided for in Section 42005 of the Vehicle Code. Nothing in this subdivision precludes an insured from also enrolling in a driver improvement course.

SECTION 64. Section 11628.4 of the Insurance Code is added as follows:

11628.4. Good driver discounts.

Based on the actuarial and loss experience data available to each insurer, every admitted insurer may provide for an appropriate percentage of reduction in premium rates for motor vehicle liability insurance for good drivers who have not been involved in any accident in the last three years for which the insured was at fault, as determined by the insurer, and who have not been convicted within the last three years of a violation of Division 11 (commencing with Section 21000) of the Vehicle Code, except Chapter 9 (commencing with Section 22500) of that division, or of a traffic related offense involving alcohol or narcotics.

SECTION 65. Section 12900 of the Insurance Code is reenacted as follows:

12900. *Appointment; term.*

The commissioner shall be appointed by the Governor, with the consent of the Senate and shall hold office for a term of four years, coextensive with the term of office of the Governor.

SECTION 66. Severability.

Except as provided in Insurance Code Section 12020, if any provision enacted, reenacted or amended by this initiative or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect any other provisions enacted, reenacted or amended by this initiative or the application thereof which can be given effect without the invalid provision or application, and, to this end, except as provided in Insurance Code Section 12020, the provisions enacted, reenacted or amended by this initiative are deemed severable.

SECTION 67. Inconsistency with Other Initiatives.

The provisions of this initiative constitute an integrated program of insurance reform and are intended to occupy the field of insurance reform in the election in which they are adopted. If this initiative receives a higher number of votes than another initiative statute adopted at the same election as this initiative, such other initiative statute shall not have any force or effect to the extent that its provisions specifically relate to the business of insurance or the regulation of that business by this State.

SECTION 68. Amendment.

Except as provided in section 20 of this initiative, the provisions of this initiative statute shall not be amended by the legislature except by another statute passed in each house by roll call entered in the Journal, two-thirds of the membership concurring, or by another statute that becomes effective only when approved by the electorate.

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84502. "Committee" means any committee, as defined in Section 82013 of the Government Code, which has made expenditures of fifty thousand dollars ($50,000) or more, in support of, or in opposition to, an initiative.

84503. "Advertisement" means any general or public advertisement which is authorized and paid for by a committee for the purpose of supporting or opposing an initiative. "Advertisement" does not include a communication from an organization to its members.

84504. "Industry" means those individuals and persons who derive economic benefit from the manufacture, sale, or distribution of a like or similar product, commodity, or service, including but not limited to professional services.

84505. "Person" means any individual, business, and any other organization up of persons acting in concert.

"Contributions" means the cumulative contributions of a committee for th beginning with January 1 of the year prior to the year during which the initiative is to be voted upon and ending with the closing date for the campaign finance disclosure report whose filing deadline precedes the dissemination to the public of an advertisement by seven days or more. A committee may optionally compute its contributions using only items required to be individually itemized on State campaign finance disclosure reports.

84507. Any advertisement authorized by a committee shall include a statement that each of the following, where applicable, is a major funding source:

(a) Any industry which is both the largest industry contributor to the committee and whose combined contributions to the committee are five hundred thousand dollars ($500,000) or more, or are fifty thousand dollars ($50,000) or more and constitute 25 percent or more of all contributions.

(b) A person whose contributions to the committee are one hundred thousand dollars ($100,000) or more and who is the largest contributor.

(c) Corporations as a group when their combined contributions to the committee are one hundred thousand dollars ($100,000) or more and constitute 50 percent or more of all contributions, and unions as a group when their combined contributions to the committee are one hundred thousand dollars ($100,000) or more, and constitute 50 percent or more of all contributions.

(d) Out-of-state contributors as a group, when their combined contributions to the committee are one hundred thousand dollars ($100,000) or more, and constitute 50% or more of all contributions.

84508. If there are more than two major funding sources, the committee is only required to disclose the first two applicable funding sources, in the order they are listed in in Section 84507.

84509. Any disclosure statement required by this chapter shall be printed clearly and legibly in a conspicuous manner, or, if the communication is broadcast, the information shall be spoken.